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25 April 2009

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Power to the people

RPSGB special general meeting: full report

See pages 4 and 10

Nasacort Allergy is now available for pharmacy. Its thixotropic[1], once-a-day formulation stays where it's sprayed for maximum effect against hayfever symptoms – and with no strong odour or taste, patients prefer it over Beconase® and Flixonase®[2,3]. Give them Nasacort and help avoid problems whenever hayfever's around. For more information about Nasacort Allergy, and copies of training materials and point-of-sale items, please contact your local Laser Healthcare Pharmacy Business Manager or call 01202 780558.

Stays where it's sprayed

NASACORT® ALLERGY NASAL SPRAY PRESCRIBING INFORMATION
Presentations: Each bottle of Nasacort Allergy Nasal Spray contains 3.575 mg triamcinolone acetonide and provides at least 30 actuations each containing 55 micrograms of active compound after initial priming. **Indications:** Treatment of the symptoms of seasonal allergic rhinitis. **Dosage and Administration:** Patients aged 18 years and over: recommended dose is 220 micrograms as 2 sprays in each nostril once daily. Once symptoms are controlled patients can be maintained on 110 micrograms (1 spray in each nostril once daily). The minimum effective dose should be used to ensure continued control of symptoms. Children: not recommended for children or adolescents under 18 years of age. Medical advice should be sought if symptoms worsen or persist after 14 days treatment. **Contraindications:** Hypersensitivity to any of the ingredients of this preparation or an infection in the nose. **Warnings and precautions:** impaired adrenal function, patients taking steroids should consult their doctor before using this product, recent nasal surgery or prolonged nose bleeds, pregnancy or lactation. There are rare reports of localised candida albicans infections in which case product should be discontinued and appropriate therapy instituted. This product should not be used for longer than 3 months without consulting a doctor. **Side-effects:** The most commonly reported adverse reactions are rhinitis, headache and pharyngitis. Respiratory disorders: epistaxis, nasal irritation, dry mucous membrane, nasosinus congestion and sneezing; rarely, nasal septal perforations. In clinical trials these adverse reactions with the exception of epistaxis, were reported at approximately the same or lower incidence as placebo treated patients. Skin or subcutaneous disorders: rarely allergic reactions including rash, urticaria, pruritus and facial oedema. Systemic effects of nasal corticosteroids may occur particularly when prescribed at high doses for prolonged periods. **Legal Category:** P.

Product Licence Number: PL 04425/0605 **Recommended selling price: £4.95. Refer to Summar of Product Characteristics for full prescribing information. Further information is available fro the Marketing Authorisation holder: sanofi-aventis, One Onslow Street, Guildford, Surrey, GU 4YS. Date of Revision of Prescribing Information: October 2008.**

References: 1. Nasacort Summary of Product Characteristics, 2008. 2. Lumry W et al. A comparis of once-daily triamcinolone acetonide aqueous and twice-daily beclomethasone dipropionate aqueou nasal sprays in the treatment of seasonal allergic rhinitis. Allergy Asthma Proc 2003;24(3):203-1 3. Stokes M et al. Evaluation of patients' preferences for triamcinolone acetonide aqueous, fluticason propionate, and mometasone furoate nasal sprays in patients with allergic rhinitis. Otolaryngol Hea Neck Surg. 2004; 131(3):225-31.

PIP code 342-5501.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk Adverse events should also be reported to the sanofi-aventis Drug Safety Department on 01483 505515.

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Winner for news coverage

> IT'S VITAL THAT WE HAVE A STRONG PROFESSIONAL BODY – ONE THAT HAS THE SUPPORT AND TRUST OF ITS MEMBERS

Lambeth bashing has become so commonplace recently that it's in danger of becoming recognised as an Olympic sport.

Whether it's fee rises or a perceived lack of support for grassroots pharmacists, our professional body is all too readily the target of the profession's ire.

And while Lambeth's end-of-year school report will recognise that there are occasions when the venerable institution can and should do better, just how fair is it to blame the RPSGB for the latest perceived transgression?

Last Sunday, over 130 pharmacists attended a special general meeting to challenge the RPSGB's stance that only pharmacists registered with the planned General Pharmaceutical Council have the right to use the protected title 'pharmacist'.

That an overwhelming majority voted to allow pharmacists to retain the right to their title, even if they do not register with the regulatory body, clearly demonstrates how highly pharmacists regard membership of their chosen profession.

And rightly so. It takes years of hard work and dedication by individuals and by the profession as a whole to win the trust of the public, who we strive to serve. And the privileges that come with achieving professional status reflect the high regard and trust in which we in turn are held by the public and government.

But if we allow every pharmacist – whether registered with the regulatory body or not – to use the title, will this undermine the profession? Perhaps not from the point of view of some, but certainly from the public's viewpoint. We all know people who can't tell the difference between a surgery receptionist and a pharmacist, so how will they distinguish a 'registered pharmacist' from a run-of-the-mill everyday 'pharmacist'?

The RPSGB is caught between a rock and a hard place. As a professional body it needs to assure pharmacists (its future members) that it understands their reasons for wanting to continue to use the title. But with its regulatory hat on, its primary objective must be to ensure that only pharmacists registered with the regulator can publicly call themselves pharmacists.

As the profession takes on greater responsibility for its patients, it's vital that we have a strong professional body acting as our figurehead – and one that has the support and trust of its members.

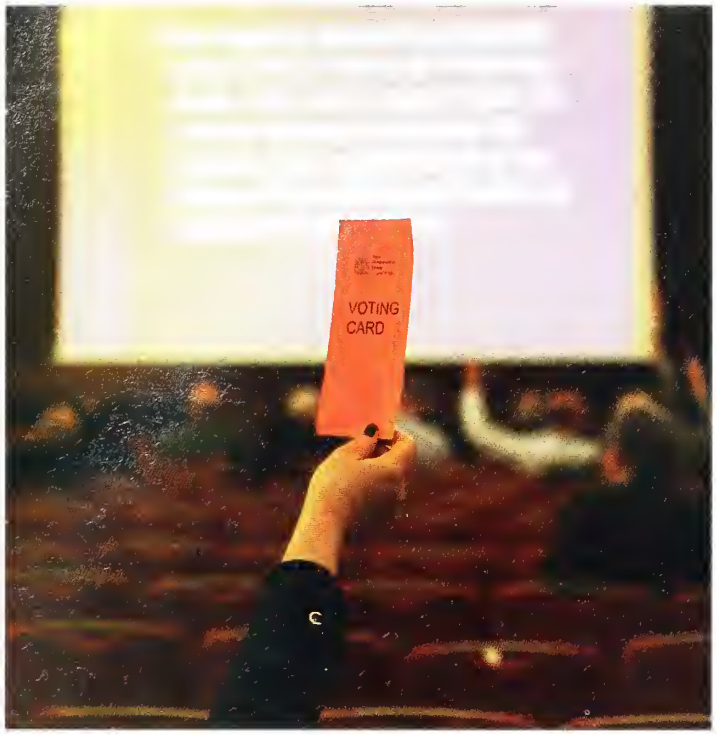
In four weeks' time the RPSGB Council will look again at this barbed issue. Whatever decision it makes – and it's difficult to see how it can do anything other than stand by its original view – perhaps it is time to put our differences aside and support the Society's need to strike a balance between supporting the profession and protecting the public.

Gary Paragpuri, Editor

Features

Pharmacist title ruling goes to Council as members force rethink

Special general meeting votes three to one against Society recommendations on use of title



Chris Chapman

RPSGB members have voted against Society proposals to restrict the use of the 'pharmacist' title to those registered with their professional regulator.

The Society's Council will now consider whether to make a policy U-turn following the result. In addition, the Society has written to the Department of Health (DH) to inform health ministers of members' views which were aired at a special general meeting last Sunday.

Members voted three to one against Society proposals that would see the title pharmacist restricted to those registered with the General Pharmaceutical Council. The RPSGB's president played down the defeat as "par for the course".

Steve Churton said: "That was anticipated. In the history of SGMs it's a rare motion that actually gets voted down."

The Society Council will meet on May 20 to discuss whether to change recommendations on restricting the title pharmacist.

Mr Churton added: "[The Council] will consider what was said at the SGM and make decisions [on] whether any new information has been brought to the table, which indicates whether the Council should change its position."

Buckinghamshire pharmacist John Rees, one of 33 signatories who triggered the SGM, said he was "pleased" all the motions went through. Mr Rees called on the Society to fulfil its "clear mandate" to discuss members' concerns with the DH and PRLOG.

Mr Churton said he had written to the chief pharmaceutical officers of the home countries, as well as the chairman of GPhC steering group PRLOG, to inform them of the result.

When asked if the divisions between the RPSGB and members displayed at the SGM, would weake plans for the new professional body Mr Churton said: "I don't believe thi issue will have that effect."

The SGM was called after opposition to the RPSGB's reponse to the draft Section 60 order, which outlines the future of pharmacy from 2010.

See a full list of motions and results in our in-depth special report from the SGM

See p10

Motions passed three to one at SGM

Motions to allow members of the future professional body to use the title of pharmacist were passed overwhelmingly at last Sunday's SGM.

Each of the five announced motions, and an additional motion tabled shortly before the event, received backing from around three quarters of the 137-strong audience at the Park Plaza Riverbank Hotel in London.

All six motions centred around opposition to Society proposals that the DH restrict the title pharmacist to those registered with the new GPhC. **CC**

Society promises refund as fees increase

RPSGB members who do not wish to join the new professional leadership body as well as the regulator when the Society splits next year will get a partial refund on their 2010 fees.

The commitment was made by the Society's director of finance and resources as the RPSGB proposed a 2.2 per cent increase in fees for next year.

Bernard Kelly said the Society had considered setting two fees in anticipation of the planned split on April 1 as "more transparent". But a "degree of uncertainty" over this target date and the needs of the planned regulator meant a single fee, proposed at around £422, was the only option.

Instead, members who pay 2010 RPSGB retention fees but do not wish to join the post-split voluntary leadership body would receive a refund, after the amount of money required to run the regulator for the remainder of the year was transferred.

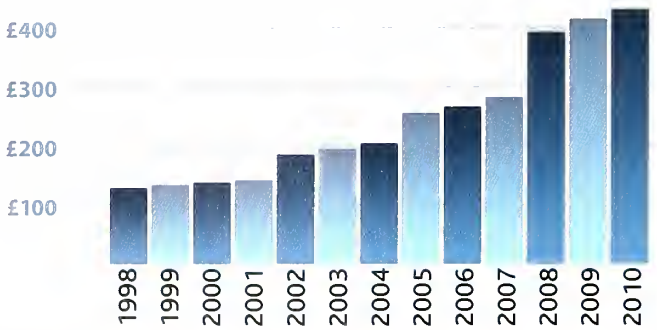
Mr Kelly said: "We would not want to appear to be arrogant with our members and say, it's tough, you have to join [the professional body] until the end of the year."

The refund size would depend on when the General Pharmaceutical Council took over regulation, and it financial requirements, he added. It was "too early" to detail how refunds would be made.

The proposed 2.2 per cent hike is above the headline rate of inflation (retail price index, RPI), which was this week announced to have fallen below zero for the first time in 50 years, to -0.4 per cent. However, it below the government's preferred measure of inflation (consumer pri index, CPI), at 2.9 per cent.

The proposed increase will be under consultation (at www.rpsgb.org) until July 17.

RPSGB practising retention fees 1998-2010



President vows to fight 'unfair' dispensing laws

Society approaches minister in bid for legislative change

Max Gosney

RPSGB president Steve Churton has pledged to tackle "manifestly unfair" laws that make dispensing errors criminal offences.

The RPSGB president admitted he had made dispensing errors and vowed to free pharmacists from the threat of criminal prosecution for such mistakes.

His comments came as support continued to flood in for Elizabeth Lee – the locum punished with a suspended jail sentence for a dispensing error.

The RPSGB president said: "I freely admit, I'm not a perfect pharmacist and I very much doubt any one of our members could say...they have never made a mistake...That is why the current legislation has to change."

The RPSGB had approached pharmacy minister Phil Hope in a bid to push for decriminalisation, Mr Churton said. However, he appeared cautious over the chances of forcing a law change. "How persuasive it will be I don't know because I haven't had the conversation. But, I hope for it to be persuasive."

The RPSGB president said it was "heartening" to see so many pharmacists demanding a law change in light of Mrs Lee's ordeal. He also hit back at critics who claimed the Society had not done enough to support Mrs Lee who was sentenced at the Old Bailey earlier this month.

Mr Churton said: "Any perceptions of silence on our behalf is due to the fact we have regulatory responsibilities."

Mrs Lee was sentenced for dispensing beta-blockers instead of steroids to an elderly woman who later died.

She bore no factual or legal responsibility for the woman's death, the court heard. However, she was still sentenced under terms of the 1968 Medicines Act.

Mr Churton said pressurised working conditions were a factor in dispensing errors. This was "not good enough" for pharmacists or patients, he said.

Steve Churton: With your support we can change the law

See letters p15

The RPSGB has approached the health minister in a bid to decriminalise dispensing errors, says president Steve Churton

No decision on Elizabeth Lee action

The prospect of further disciplinary action against Elizabeth Lee still remains unclear with the RPSGB refusing to comment on whether it will investigate the former locum.

Mrs Lee was handed a suspended jail sentence for a dispensing error by the Old Bailey earlier this month.

The Society has said it will be required to deal with the matter under its regulatory responsibilities.

However, the RPSGB said it could not comment on whether this would involve disciplinary proceedings.

The Society also refused to give a deadline by which the organisation will have made a decision on whether to investigate or not.

Society rules dictate criminal convictions that lead to a suspended sentence are referred to the organisation's disciplinary committee.

Such referrals only take place when the registrar has completed any necessary investigations appropriate to the allegation, RPSGB rules state.

Mrs Lee resigned from the register immediately after her dispensing error came to light. However, the former locum remains on the non-practising register, the RPSGB confirmed.

Mrs Lee can therefore still face disciplinary proceedings if the Society decides to take action. **MG**

Salicylate gels advice

The MHRA has advised that products containing salicylate salts should not be used in under 16s as they have the same effect on the body as aspirin, which is contraindicated in this group. The measure is precautionary and the products affected are Bonjela and Bonjela Cool Mint Gel.

Generics Supplement

Don't miss the C+D Generics Supplement which will be available in the C+D email newsletters for the next four weeks. It lists PIP codes for unbranded lines in pack sizes from counter and dispensary to small-scale manufacture. Sign up to the free e-newsletter at **www.chemistanddruggist.co.uk/register**

Scotland PHS topics

The health promotion campaign topics for Scotland's Public Health Service have been announced by the Scottish Government. A full list of the nine topics is available at **http://tinyurl.com/cezy4z**. For funding details, see **http://tinyurl.com/cogoj4**

Obesity module

The latest C+D Skills for Public Health module is now available. The module, included in this week's issue, tackles obesity management and suggests how pharmacists can tailor services to local needs.

Drug cuts diabetes risk

Voglibose reduces the risk of developing type 2 diabetes when used in addition to lifestyle change, a study has found. High-risk patients taking the alpha-glucosidase inhibitor had a 40 per cent lower risk of progression at just under one year. **www.thelancet.com**

McNeil clarification

In McNeil Products' migraine training module, distributed in last week's OTC, there was a printing error on page 30. The answer options for question 5 should read:

a) 1 in 2; b) 1 in 3; c) 1 in 6.

The corrected version is available at **www.chemistanddruggist.co.uk/stafftraining**

Dispensary talk

Have you ever made a dispensing error?

"Yes. If you make an error you try and rectify it as quickly as you can. Sometimes you have to go out and see the patient, but fortunately I've never had a serious dispensing error."
John Gibson, Lloydspharmacy, Manchester

"The obvious answer is yes. I have great reservations about any pharmacist who says they haven't made one, because it means they're not aware of it."
Gordon Couper, Handbridge Pharmacy, Chester

Web verdict

Yes 94%

No 6%

Armchair view: Nearly all respondents recognise that they have made dispensing errors in the past and could have been in the shoes of Elizabeth Lee, who received a suspended jail sentence for an error earlier this month.

Next week's question:
Have you been asked for weight loss drug Alli yet? Vote at www.chemistanddruggist.co.uk

Sector shapes up for Alli

Expectation builds as OTC weight loss drug hits the shelves

Jennifer Richardson

Pharmacists across the UK were awaiting the launch of OTC weight loss drug Alli as C+D went to press this week.

The pharmacy version of orlistat was officially launched on Wednesday, eagerly anticipated since GlaxoSmithKline applied for a European licence in 2007.

Pharmacists and pharmacy technicians from 10,000 premises had already completed "comprehensive, widespread" training on selling Alli, GSK said. It was committed to ensuring pharmacists could make the most of an "exciting business opportunity", said James Hallett, general manager of GSK Consumer Healthcare UK.

As well as workshops, online distance learning is available at www.mypharmassist.co.uk.

Both the NPA and the RPSGB said Alli would increase pharmacists' ability to help overweight and obese patients with a "proven medicine".

But the organisations were also eager to emphasise that Alli should not be seen as a "miracle cure" or "magic bullet", a danger that many media reports of its launch have highlighted. NPA chief executive John Turk said: "The support that patients will receive from pharmacists when taking this medicine will encourage healthy eating habits and enable a healthy long-term lifestyle change."

Northern Irish community pharmacist Terry Maguire, consulted by GSK on developing the programme, said the training was "very much focused on pharmacy developing a service role around the product, rather than just seeing it as another OTC remedy".

Alli offers a chance for spin-off weight loss services, say experts

What the papers say

The launch of Alli attracted much attention from national news outlets, including the websites of The Times, The Guardian, The Daily Telegraph and BBC News.

Most reports focused on warning the OTC orlistat drug was not a "miracle cure" or "magic bullet", something both manufacturer GSK and pharmacy bodies were keen to emphasise.

Some stories also reported concerns around misuse. The Daily Telegraph quoted one expert as saying there was "huge potential" for the drug to be "misused", including by those under 18 for whom the drug is not licensed.

National Obesity Forum chair Dr David Haslam agreed there was "always the possibility that it could get into the wrong hands", but told C+D this could also happen if it was supplied through general practice. Dr Haslam believed pharmacy supply would be "responsible and appropriate", he added. **JR**

What are your thoughts on the Alli launch?

jrichardson@cmpmedica.com

Summer deadline for stage one EPS

Contractors who have not yet installed release 1 of the electronic prescriptions service (EPS) but have received payment for it have been warned to deploy by July 31.

If they don't, PCTs could possibly try to reclaim the payment or impose conditions on pharmacies to stay on PCT pharmacy lists, C+D has been advised.

Pharmacies that received the release 1 allowance payment of £2,600 in 2005-06 are expected to be ready for release 1 by the end of July unless there are mitigating circumstances.

The amount was originally charged back to PCT budgets and Lindsay McClure, head of information services at PSNC, said failure to deploy "may lead to conflict with PCTs".

Noel Wardle, a solicitor at healthcare law specialists Charles Russell, said if pharmacies were found to be claiming for a payment to which they were not entitled, PCTs could try to reclaim that money.

He added that if contractors were felt to be prejudicing the efficiency of the NHS then PCTs could take action against them.

This action could include interim suspensions or imposing conditions which contractors must meet to stay on the PCT's pharmacy list.

It is thought that around 10 per cent of pharmacies have yet to deploy release 1, although it is not clear how many of those have received the payment. **ZS**

Release two pilot site identified

C+D understands that a pharmacy in Nottingham has been identified as a possible first site to pilot release 2 of the Electronic Prescription Service (EPS). A Connecting for Health spokesperson said the agency expected the initial implementation sites to start commissioning activities in April.

No pharmacy systems are currently release 2 compliant. However, Cegedim Rx is hoping to test its system in a pharmacy in Leeds before the end of April, managing director Simon Driver has told C+D. **ZS**

new

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MyPharmAssist.co.uk

Product Information **alli** 60 mg hard capsules (orlistat) **Indication** Weight loss in adults BMI ≥ 28. **Dosage** *Adults (18 or over)* One capsule within an hour of each of three main meals. Max 3 caps/day for up to 6 months. Use with lower fat mildly hypocaloric diet. If no weight loss within 12 weeks refer to HCP. Diet and exercise should start prior to treatment. **Contraindications** Hypersensitivity to ingredients, concurrent treatment with oral anticoagulants or ciclosporin, chronic malabsorption syndrome; cholestasis; pregnancy, breast-feeding. **Special warnings and precautions** See HCP if on amiodarone or medication for hypertension, hypercholesterolemia or diabetes as control of these conditions may improve necessitating alteration of therapy. Risk of GI symptoms increases with fat consumption [illegible] at bedtime. See GP if rectal bleeding. Oral contraceptive [illegible] be reduced if severe diarrhoea. [illegible] Drug interactions Ciclosporin, oral anticoagulants, acarbose, amiodarone. **Pregnancy and lactation** [illegible] pregnancy or lactation. **Side effects** See SPC for full [illegible] gastrointestinal eg oily stools, urgency [illegible] reduced by low fat consumption. H[illegible] liver enzymes, anxiety. Hypersensitivity [illegible] bronchospasm, angioedema, [illegible] **Legal category** P **Marketing Authorisation Holder** [illegible] Greenford, Middlesex, UB6 0HE **MA Number** [illegible] **Pack size and RSP** 42s £[illegible] **Last revised** [illegible]

Avicenna conference

Human resources help

Avicenna members will get an HR package next month which includes a 24-hour helpline and risk assessment tools. The group is also doubling the number of SOPs it provides to over 100.

Cat M cash 'lost'...

The government has clawed back around £1.4 billion using the category M mechanism in the past 3.75 years, but only £900 million of this was reinvested in services and the rest has been "lost forever", according to Sigma Pharmaceuticals md Bharat Shah.

... while products added

Price per dose could be introduced into category M this year and is likely to be based on the most popular pack sizes, delegates at last week's Avicenna conference heard. A further 90 products are also being considered for inclusion in category M, which currently lists 515 products.

PI market to fall to record low, says expert

Sales of parallel imports could be as low as £225m this year

Gary Paragpuri/Chris Chapman

Sales of parallel imported medicines in the UK will fall this year to their lowest level for four years, according to an industry expert.

Sales data from the UK's 12 largest parallel distributors suggested that the market for PIs in the UK could be around 40 to 50 per cent of 2008's levels, Bharat Shah, md of Sigma Pharmaceuticals told last week's Avicenna conference in Las Vegas.

From an estimated £1.1 billion in 2006, sales of PIs plummeted to £563m last year. And figures could be as low as £225m this year, Mr Shah said.

Sales had been affected by a number of strategies implemented by manufacturers such as quotas and direct-to-supply models, Mr Shah told delegates.

Worsening exchange rates also played a significant part in the collapse of the PI market, Shaun McCormick, sales director at South Cordia Healthcare Group, explained.

The plummet in PI availability was confirmed by Fin McCaul, chair of the Independent Pharmacy Federation and owner of Prestwich Pharmacy in Manchester.

He said: "It's definitely happened. It's had a dramatic impact on me. The volume has reduced and the profit from it is significantly reduced as well."

Mr McCaul's comments were supported by London pharmacist Raj Radia, who said profit margins had eroded because of the market collapse.

Mr Radia said: "I'm definitely getting fewer and fewer PI products. And of course it's having an impact on my business."

Have you seen a dip in PI products at your pharmacy? Email haveyoursay@cmpmedica.com

Bharat Shah: the UK PI market could fall by 50 per cent in 2009

Sherwood MP Paddy Tipping (centre) became the latest politician to take part in C+D's Building Bridges campaign when he visited a branch of Burrows & Close Pharmacy in Calverton. During his visit, attended by members of Nottinghamshire LPC including chair Rob Severn (left), he discussed the upcoming local minor ailments scheme with staff including pharmacy manager Jon Throup (right). The pharmacy provides services including smoking cessation, supervised methadone and subutex consumption, and chlamydia screening. Mr Tipping said he hoped his visit would highlight these services to the public. He said: "These schemes go a long way to keep surgery visits down and provide valuable advice outside surgery hours."

Avicenna to share £2m

Avicenna will share a £2 million profit pot with its members in 2009, its chairman has revealed

Members would share a multimillion pound payout in addition to a dividend this year, an increase on the £1.3m payout in 2008 and £700,000 in 2007.

The 1,000-strong group also planned to increase its membership to one third of the independent sector within a year, Mr Gration told delegates at the group's Las Vegas conference last week. Avicenna would continue to seek a stock market listing but this depended on market conditions improving, he added. Avicenna announced a 16th successive year of growth last month. **GP**

Why pharmacists need back-up in the fight against crime

See p26

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E45

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No wonder 70% of patients rated their improvement as 'good' or 'very good'.[1]

And now that it's in a larger 500g pack, the solution goes even further for your patients.

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E45

HEALTHY SKIN FEELS GREAT

Essential Information E45 Itch Relief Cream. E45 Itch Relief Cream contains lauromacrogols 3.0% w/w and urea 5.0% w/w. **Uses:** For the treatment of pruritus, eczema, dermatitis and scaling skin conditions where an antipruritic and/or hydrating effect is required. It may also be used for the continued treatment and follow-up treatment of these skin diseases. **Dosage and administration:** Adults, the elderly and children: Apply to each affected area twice a day. The duration of treatment depends on the clinical response. **Contraindications:** Patients with known hypersensitivity to any of the ingredients. It should not be used to treat acute erythroderma, acute inflammatory, oozing or infected skin lesions. **Special warnings and precautions for use:** May cause irritation if applied to broken or inflamed skin. **Pregnancy and lactation:** There are no specific restrictions concerning its use during pregnancy, but it is not to be used on the breasts immediately prior to breast feeding during lactation. **Undesirable effects:** E45 Itch Relief Cream has been reported to cause a burning sensation, erythema, pruritus or the formation of pustules. Contact allergy has also been reported. **Package quantities:** 50g and 100g tubes, 500g pump pack. **RRP (excluding VAT):** 50g £3.40, 100g £4.63, 500g £16.42. **Legal category:** GSL. **Product licence number:** PL 00327/0122. **Product licence holder:** Crookes Healthcare Ltd, Nottingham NG2 3AA. **Further information is available from:** Reckitt Benckiser UK Healthcare, Dansom Lane, Hull HU8 7DS. **Date of preparation:** April 2009.

Information about adverse event reporting can be found at www.yellowcard.gov.uk Adverse events should also be reported to the Medical Information Unit, Reckitt Benckiser, Hull (0500 455 456).

Reference: 1. Vieluf D *et al. Z Hautkr* 67 (9): 816-821.

Date of preparation: April 2009.

NPA1109

Action group fights for right to pharmacist title

SPECIAL REPORT Over 100 RPSGB members attend SGM

Zoe Smeaton

Are you a pharmacist, non-practicing pharmacist or former pharmacist?

This was the question up for debate in Lambeth last weekend, as RPSGB members gave up their Sunday afternoons to take the Society to task over recommendations on who can call themselves a pharmacist in future.

The RPSGB has told the government that only those registered with the General Pharmaceutical Council (GPhC), which takes over as pharmacy regulator next year, should be allowed to use the title 'pharmacist'. People on a possible non-practicising register could call themselves 'non-practicising pharmacists' and those not registered with the GPhC would be 'former' or 'retired' pharmacists.

The proposals caused anger amongst retired pharmacists and those with non-patient-facing roles in industry and academia who would not be required to register with the GPhC. An action group headed by Buckinghamshire pharmacist John Rees was established on the issue, and triggered a special general meeting. And on Sunday more than 130 people gathered to air their views.

Business began with Mr Rees presenting the case for motion one. It is against pharmacists' human rights not to be able to refer to themselves as pharmacists unless they register with the General Pharmaceutical Council, he suggests. He says the Society proposals would leave non-registered pharmacists feeling disenfranchised and calls it "ludicrous" for them to have to refer to themselves as "former pharmacists".

Instead, those voting for the motions suggested pharmacists registered with the GPhC be termed 'registered pharmacists' with members of the professional body called 'pharmacists'.

Mr Rees was certainly not alone in this view as other members later backed him, throwing scorn on the Society. One member even billed the Society's proposed rules as "draconian" and others threatened not to join the new professional body or said they would defy the rules and call themselves pharmacists anyway.

Six motions on use of the pharmacist title were debated at the special general meeting last Sunday. All were carried by a convincing margin

But some Council members and others backing the Society were equally vocal, calling the action group's proposals "offensive" and saying if the Society changed its stance now it could look weak in the eyes of those in power.

Personal tales dominated the event, from the chief hospital pharmacist who found the suggestion that she was not a practicising pharmacist offensive, to the pharmacist who spent his time on committees and in advisory roles and wanted to continue to promote himself as a pharmacist.

One delegate had even flown all the way from Germany to attend the event. They pointed out the irony that while the Society's proposed rule would mean they were not a pharmacist while working in their non-patient-facing role, they would be a "retired pharmacist" when they stopped work. Another stressed the fact that they would be allowed to practice as a pharmacist if recalled for duty in a national emergency, suggesting they would then become a "reborn" pharmacist.

But although all six motions were passed quite convincingly, the voice of the opposition came through loud and clear too.

Nick Barber, a Council member and professor of pharmacy practice, said the proposed motions made the profession look "politically naive" and could have negative implications if taken all the way to the Department of Health. Professor Barber told C+D the proposed measures could loosen the protected term 'pharmacist' and cause confusion for the public.

Others opposed motion three (see box) saying that being a pharmacist should be about actions now, rather than a qualification gained. And John Gentle, a Council member, pointed out that this could allow pharmacists who had been struck off to call themselves pharmacists.

Jonathan Mason, the DH's community pharmacy tsar, told C+D that he was concerned that the views of the 100 or so pharmacists supporting the motions did not necessarily reflect those of all the Society members. He would have liked to see more young pharmacists attending. And in a room dominated by white males in their 60s or beyond, this seems a fair point.

But representative or not, the members won their case, and now all eyes must turn to the Society to see what will happen next.

THE MOTIONS

Motion 1
This meeting rejects proposals to make it a criminal offence for anyone not registered with the GPhC to use the pharmacist title.
CARRIED
For: 101
Against: 34

Motion 2
This meeting rejects proposals to make it a criminal offence for anyone not registered as a pharmacist by the GPhC to practise as a pharmacist.
CARRIED
For: 95
Against: 31

Motion 3
This meeting supports the proposition that the title pharmacist should be used only by any person with a suitable degree or professional experience accredited by the RPSGB or is a future member of the new professional body.
CARRIED
For: 91
Against: 30

Motion 4
This meeting supports the suggestion that the title 'registered pharmacist' is a suitable restricted title for those adequately qualified and registered with the GPhC.
CARRIED
For: 75
Against: 26

Motion 5
This meeting considers that the definition of "practice" . must be limited to the activities of those pharmacists engaged in the provision of services, care and advice to patients and the public.
CARRIED
For: 51
Against: 36
Abstain: 3

Motion 6
This meeting calls on the RPSGB Council to seek talks with the government to secure changes to its recommendations on the pharmacist title in line with the wishes of this meeting.
CARRIED
For: 61
Against: 4
Abstain: 15

The complete package

Dispensing continues to be an issue of debate, looking to ensure that the dispensing process in pharmacy is a slick operation that enables the highest possible number of prescriptions to be processed in the shortest amount of time, whilst remaining efficient and accurate and professional.

Working to achieve this, pharmacist Nazim Ali at Streatham Pharmacy has upgraded his dispensing system with the latest tools in pharmacy technology, an ARX dispensing robot and implemented other support to ensure a smooth dispensing process, including use of the new look packaging from Actavis.

Pharmacist Nazim Ali comments: "We have undergone a complete pharmacy refit, transforming the space into a European style set up, incorporating the dispensing robot which allows me to spend more time with patients whilst dispensing. The refit has doubled the pharmacy space and soon-to-be completed is a fully functional clinic in the basement offering a private GP clinic and consultancy rooms, allowing the pharmacy to offer a range of PCT funded services such as MURs, in accordance with the pharmacy contract."

Pharmaceutical companies have also been working to provide support with the dispensing process. Actavis has recently launched its entire portfolio of over 350 own label generic products in a new look packaging. After rigorous testing and endorsement from the National Patient Safety Association (NPSA), the new Actavis livery has been designed to minimise errors and reduce confusion, making it easy as easy as possible for patients to take the medicines correctly.

Pharmacist Nazim Ali comments: "Accuracy and speed are key to the dispensing process. The robot ensures the medicine is picked quickly and the Actavis packaging is easily identifiable, making the medicines easy to dispense correctly – both enabling me to spend more time discussing medication with the patient and to build the strong relationships required to ensure

patients are taking their medicines correctly.

"The Actavis patient information leaflets are also clearly laid out and easy for the patients to read. Plus, for the robot, the packaging sizes provide space optimization, compared with some of the bulky packaging we often see."

Jonathan Wilson, Marketing Director, Actavis UK, comments: "We have worked closely with customers to ensure that the new packaging meets the latest guidelines to maximise safety and compliance. The speed with which this new, rigorously tested packaging has been rolled out demonstrates our ongoing commitment and responsiveness to customer needs and to enhancing patient safety."

As the robot enables more time to be spent counselling patients, it also provides further opportunity to build strong relationships and grow repeat business. Thus, for example, equipping a pharmacist with increased opportunity to identify patients with compliance issues, and the opportunity to discuss medication and potentially carry out an MUR.

Pharmacist Nazim Ali comments: "As I continue to build strong relationships and be seen as a highly valued healthcare professional with my patients, consistency and continuity of supply of medicines is very important. Repeat prescriptions are also vital to most pharmacies, and as such, I look to provide a high service level of continuity of supply with my medication in order to increase patient loyalty and compliance and to help patients recognise specific medication, which is particularly important if they are taking a number of medications, are partially sighted or unable to read English. The Actavis packaging is easy for them to identify and helps me ensure better patient care."

Jonathan Wilson, Marketing Director, Actavis UK, comments: "At Actavis we pride ourselves on listening carefully to customers and responding quickly to ensure that community pharmacists can take advantage of the opportunities on offer and remain at the very heart of healthcare provision in the UK."

Pharmacy is having to evolve to ensure pharmacists can be best placed to offer new and additional services to meet the local community's needs, whilst continuing to be an efficient and accurate source of medicine supply.

Pharmacist Nazim Ali concludes: "It is high time the pharmaceutical industry as a whole took the dispensing debate seriously and spent more time considering packaging and its implication on the dispensing process and overall patient care as Actavis has done."

For more information, contact Actavis UK on 0800 373 573.

actavis
creating value in pharmaceuticals

Appesat 'trains' appetite control

Goldshield Healthcare is launching an OTC product aimed at helping overweight people to gain control of their appetite and eat smaller portions.

Appesat capsules contain Bioginate Complex, a fibre complex extracted from seaweed.

According to Goldshield, the product works by expanding and stimulating hunger receptors in the stomach wall, which send a signal to the brain informing it that the stomach is full.

"Over time, the stimulation of the stomach receptors and reduced food intake can 'train' people to physically and psychologically want less food," said the company.

When combined with regular exercise and sensible food choices,

the product is claimed to help people achieve sustainable weight loss.

It is recommended that the capsules are taken with water at least 30 minutes before each meal.

Price: £29.50/50 capsules
Ceuta Healthcare
Tel: 01202 780558
www.appesat.com

Bright outlook for Joy-Rides

GlaxoSmithKline has repackaged its 'P' licensed Joy-Rides motion sickness tablets with an eye-catching new look in time for the holiday season.

Designed to improve the brand's on-shelf presence, the pack features brighter blue and orange colours and modern icons depicting different forms of transport.

A luggage tag style icon indicates that the product is suitable for children aged three and over which is a key selling point as more children suffer with motion sickness than adults.

GSK says the chewable fruit flavoured tablets are best taken 20 minutes before the start of a journey

but are also effective if taken at the onset of nausea or after a journey has begun.

Price: £2.44/12 tablets
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637
www.MyPharmAssist.co.uk

Formula for pre-term babies

SMA Nutrition is launching a nutritionally complete post-discharge formula for low birthweight and preterm infants following hospital discharge.

SMA Gold Prem 2 is a catch-up formula which should only be used under medical supervision. It is suitable as the sole source of nutrition for infants up to six months.

The formula is more nutrient dense than standard term formulae.

It contains alpha-lactalbumin, vegetable-derived LCPs, arachidonic acid, docosahexaenoic acid and nucleotides. The formula comes in a powdered format in a 400g can.

Product info:
SMA Nutrition
Tel: 01628 660633

New recipe for gluten-free rolls

Glutafin Select White Rolls and Fibre Rolls have been improved with a new recipe so that people with coeliac disease can enjoy them straight from the pack.

The gluten-free rolls have a soft texture and improved taste with the additional nutritional benefits of being high in fibre and calcium.

There is no need to microwave or warm the rolls in the oven or to freeze them as they can be stored in the cupboard for up to three months. The rolls come in packs of four and are also available on prescription.

Glutafin
Tel: 0800 9882470
www.glutafin.co.uk

Retail talk

Will Alli help you develop weight loss sales?

Yes 64%

No 36%

Off the shelf view: It was thumbs up for GSK's new 'P' weight loss aid last week, with two-thirds of pharmacies looking to develop their weight management service.

This week's question:
Will you promote the benefits of P hayfever remedies by maximizing on branded PoS material in your window during May? Vote at www.chemistanddruggist.co.uk

Granny knows best

Lifeplan Products has extended its Grandma Vine's range with Natural Vitamin E cream. The moisturising cream is suitable for dry, flaky skin conditions and can be used under make-up. In addition to vitamin E, the cream also contains calendula extract and rosemary oil.

"Vitamin E acts as a powerful antioxidant which helps to maintain skin structure by reducing free radical damage," said Lifeplan.

The Grandma Vine's range contains no colourings, perfumes, lanolin or other animal derivatives and is registered with the Vegan Society.

Price: £4.99/80g tub
Lifeplan Products
Tel: 01455 556281

Imodium On TV next week

DulcoEase: A, HTV, CTV, W, M, five, GMTV, Sat
Hedrin: five, GMTV, Sat
Merial Frontline Spot On: All areas
Seabond: All areas
Voltarol Paineze Tablets: All areas
Wartner: All areas except LWT, five
PharmaSite for next week: **Panadol** – windows, **Panadol** – in-store, **Panadol** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

New start for Nicobrevin

Aspar Pharmaceuticals has recently acquired Nicobrevin and will sell the product in the UK and Ireland from May 1.

The company is relaunching the nicotine-free product in eye-catching new blue and orange packaging which features a cigarette tied in a knot.

The four-week capsule course is designed for smokers who want to give up by helping to counteract withdrawal symptoms.

Originally invented by a pharmacist, the product is formulated to help calm the nerves, soothe the gastric system, clear the bronchial passages and improve breathing.

Each capsule contains menthyl valerate 100mg, quinine 15mg, camphor 10mg and oil of eucalyptus 10mg.

The recommended course is for 28 days only. The product is not recommended for use during pregnancy or breastfeeding.

Price: £28.00/48 capsules
Aspar Pharmaceuticals
Tel: 020 8205 9846

In brief

De Witt brand changes

Lornamead is now the licensee for E C De Witt's Witch skincare, as well as the distributor for the CCS footcare and Clinomyn oralcare brands in the UK and Ireland. Lornamead says all three brands are closely aligned with its current lines and it plans to add innovative new products to the existing Witch range.

Brodie & Stone is now the licensee for De Witt's T-Zone medicated skincare brand in the UK and Ireland.

Lornamead UK
Tel: 01276 674000
Brodie & Stone
Tel: 020 7299 7411

Nicorette update

McNeil Products says that due to an unprecedented demand for its Nicorette Inhalator (6s and 42s) over the last three months there will be an intermittent supply of the product until early June.

McNeil Products
Tel: 01628 822222

More for feet

SSL International has introduced a larger 15g version of its Scholl Advance Athlete's Foot Cream (terbinafine 1 per cent). The larger pack enables users to treat not only the affected area but both feet simultaneously, thereby reducing the risk of re-infection. The product is designed to stop the itch quickly and treat the infection in one week.'

Price and pip code: £5.49, 335-3844
SSL International
Tel: 0161 638 2000

Letters

Elizabeth Lee: your reaction

C+D has been bombarded with messages of support for the locum sentenced for a dispensing error. Here are just a handful of the sympathetic letters sent in this week.

Help us deal with the pressure

It is extremely sad to see what has happened to Mrs Lee. I, as a newly qualified locum, have worked in many stores for nine to 10 hours with no dispensary staff and no breaks. The Society has to look after us; isn't that the role of our professional body or should they just sit on the fence? It's about time the law changed – mistakes happen, it's human error. With all the pressure community pharmacists receive from employer on MURs and PCS sign-ups, isn't it about time that they too show a little more understanding to our role rather than be financially driven?

I assure you that all pharmacists are with you Mrs Lee – you have our full support.

Rajiv Shah MRPharmS, project development manager, Sigma Pharmaceuticals

C+D will pass on your messages of support to Elizabeth Lee. Please email your letters to:

mgosney@cmpmedica.com

Time to sort out our priorities

As a practising pharmacist who understands the pressures that we face in front-line pharmacy, I would like to give my full support to Mrs Lee. I also believe that dispensing errors should be decriminalised.

It is tragic that a diligent and concientious pharmacist has walked away from this profession due to this. The lack of support that we, as pharmacists, have from any of our representative bodies on this is also astounding. I am sure no GP ever has to face anything like this on their own – ask any pharmacist and they will tell you how many GP prescribing mistakes we quietly correct day in, day out – do we get any recognition for this? No!

What is the point of having long winded debates about pharmacist stress in the workplace when we cannot even help Mrs Lee, a young aspiring pharmacist who will now never serve this profession? It is time that this profession gets its priorities sorted.

Mandeep Mudhar MRPharmS, locum pharmacist, Midlands

Email your letters to:

OPINION ON THE WEB

C+D's website has been flooded by postings of support for Mrs Lee. See them at www.chemistanddruggist.co.uk/news. Here is a sample:

"Why can't we agree on a day to march publicly all over Britain to show our anger and to show our employers and our regulators that it is time for a change." **Posted by Leila Fares**

"I feel great empathy. There but for the grace of God go most of us. We aren't criminals, far from it—just human beings usually trying to concentrate for the good of all, often being interupted by many." **Posted by Jenny Meade**

"It's a very sad day for pharmacy, when one error leads to a prison sentence. The RPSGB needs to act quicker on issues like this, rather than who can legally use the title pharmacist under the new GPhC and stop wasting RPSGB members' fees!" **Posted by S Patel**

RPSGB president: I've made errors and I will fight for change

Over the past few weeks, since the sentencing of pharmacist Elizabeth Lee was made public, there has been a large amount of comment from concerned members of the profession, roundly condemning Ms Lee's sentence and the impact it has on pharmacy.

I, too, share your concerns about criminal sentencing regarding dispensing errors and I can promise the profession the Society is taking this issue extremely seriously.

At the time of writing, we are in the process of setting up a meeting with minister for pharmacy Phil Hope, to express our concerns and, hopefully, to agree on a course of action. Rest assured, we are not treating this matter lightly and any perceptions of silence on our behalf is due to the fact we have regulatory responsibilities and will be required to deal with this matter. Quite simply, the Society would be in breach of its professional duties should we comment on the specifics of this case.

Nevertheless, there is no more opportune time than now to reiterate our call to have such dispensing errors decriminalised and, instead, dealt with by the regulator. I feel very strongly about this matter. As the letter of the law stands, it is manifestly unfair to pharmacists and places unrealistic burdens and expectations upon the thousands of us who routinely perform our necessary duties each day.

I freely admit I'm not a perfect pharmacist and I very much doubt any one of our members could say, hand on heart, that they have never made a mistake in the dispensary. That is why the current legislation has to change. It's just not realistic and, as we have seen, the punishment for breaking that law could be seen as harsh.

This brings me to a second point, which ties in with the Society's Workplace Pressure campaign. Dispensing errors, and other mistakes, can occur when a pharmacist is under pressure, or has too much work to deal with, or has worked all day without a proper rest-break. All these factors can lead to mental tiredness and stress which, in turn, can lead to errors occurring. Again, this is simply not good enough – it is not good enough for pharmacists and it is not good enough for patients.

I think it is heartening to see so many of you speaking out against the current state of the law, and the current state of working conditions for pharmacists. With your support, the Society can try to change the laws by which we are governed and the rules by which you work.

If you have thoughts about your current working conditions, or ideas to help change the profession for the better, please email me at support-for-you@rpsgb.org, because I most certainly am listening.

Steve Churton, RPSGB president

Get me some appliance training, and quick!

> WITHOUT ANY TRAINING I MAY STRUGGLE TO PROVIDE EVEN THE BASIC LEVEL OF ADVICE REQUIRED

I have rarely even opened a box of stoma bags, never mind discussed the contents with a patient. I will therefore need some fairly involved training before next April if I am to have any chance of carrying out an appliance use review that serves any useful purpose.

I had few qualms about medicines use reviews because I'd spent four years studying medicines and they form the basis of my whole working life. Appliances are a completely different matter.

I will bend over backwards to obtain products if I'm given manufacturer details and code numbers, but I've rarely needed to know the difference between one appliance and the next. I know what a stoma bag is used for, and I know that male catheters are longer than the female version, but beyond that my knowledge is rudimentary to say the least. Without any training I may struggle to provide even the basic level of advice required for the essential service.

I'm more than capable of delivering anything, signposting, referring and making urgent supplies, and it's probably a good thing that these services have become formalised and therefore recognised. But I have a suspicion that stoma appliance customisation involves a pair of scissors, and that's all. I also know which part of the anatomy each appliance should be attached to or inserted into, but most patients know that already. Am I really going to be able to provide a decent service?

At least seven or eight of the nine bits of CPD I've got to do before next April will now have to be on appliances. That's easier than it sounds because I don't think there's any relevant learning material. The CPPE and other training providers don't have long to help us out on this one. I assume some accreditation will also be required before I can provide the advanced service. Twelve months is not long to draw up and deliver some decent training packages and give pharmacists the time to study them.

The new supply arrangements for incontinence and stoma products (C+D, April 18, p15) were necessary to tackle inequity between arrangements for us and appliance contractors. And they look, on the face of it, like good news for pharmacy. But we may be providing this wonderful new service for free. It's great that we will be paid for deliveries, customisation and use reviews, but this appears to be funded by a 2 per cent cut in reimbursement prices.

I guess that while most pharmacists strive to provide MURs, or at least feel guilty about not doing so, fewer pharmacies will offer an AUR advanced service. Only those with a special interest, or lots of suitable patients, will probably get involved with AURs. All the rest will simply have to put up with a slightly reduced income.

Nightmare on the high street

I had the misfortune recently to work in one of our supermarket pharmacies. What a nightmare it was and an experience never, ever to be repeated.

I walked into one of the busiest pharmacies in the home counties to be greeted with: "You will be on your own today – we are all going off to attend a training lecture at a hotel." "Great," I thought. Four members of staff missing. What about me? I suppose the attitude is: "You're the locum. Cope!" I should have walked out there and then. What followed was a disgrace and lethally dangerous to the public. For such was the torrent of scripts that poured into the pharmacy, I was unable to cope. I can work as efficiently as the next guy but flesh and blood can only do so much.

Patients poured in, most had more than one script, each form with multiple items and huge quantities. The phone went constantly, I had to keep going to the counter to speak to customers and there were several requests for the morning-after pill.

There were numerous grumbles about non-arrived repeats; two patients wanted to complain to the manager who was nowhere to be seen.

Then after a couple of hours of bedlam, it happened. I made a dispensing mistake. I was labelling the wrong box. Then I mis-labelled another item. "Take a break," I said to myself. When I went back nearly a dozen people were queuing, all clutching at least one green form. Obviously leaving was a big mistake and my situation was now even worse. In the dispensary the order had arrived and a pile of blue trays was stacked in front of the computer.

By early evening the pile of trays was probably the best part of two feet high. Then a script arrived with directions that were clearly nonsense. I quickly rang the surgery. At a little after six o'clock the £120,000 a year overworked doctor had already gone home. "He started at nine o'clock," said the receptionist, "and he's had a busy day." "Tough," I thought. We will have to phone tomorrow.

By now the queue was almost out of the store and blocking the entrance. Still they poured in, a human tide of patients and prescriptions. By closing time I was almost on the point of collapse and drove home to the strains of Classic FM.

"Had a good day, dear?" asked my wife. My reply was barely printable.

25.04.09

Features

Your weekly CPD revision guide

Module 1474

update

Treatments for prostate cancer

Naomi Sharma

60 second summary

What is the role of drugs in prostate cancer?

Androgen deprivation is used to prevent tumour growth in prostate cancer patients not suitable for surgery or radiotherapy, and is usually achieved using LHRH agonists. However, anti-androgens may also be given to prevent the initial increase in testosterone seen when LHRH is started or if PSA rises.

What are the other treatment options?

Other treatment approaches in prostate cancer include surgery, radiotherapy and 'watchful waiting'. However, the best treatment options for patients with localised prostate cancer remains unclear, and a major issue is the lack of evidence on this important question.

This article (Module 1474) can be used for the following CPD competencies:
G1a, G1c, G1d
See http://tinyurl.com/68ox7b

Once a patient has been diagnosed with prostate cancer and has had staging investigations, the treatment options are explained.

The treatment choices depend on both patient and tumour factors. Patient factors include life expectancy, co-morbidity and individual preference. 'Radical' treatments, performed with a curative intent, require a life expectancy of at least 10 years for the procedure to be of benefit to the patient. Age has previously been a contraindication, but with increases in life expectancy, many centres now offer radical treatment to men over the age of 70. Another factor in decision-making is the presence of co-morbidities such as severe chronic obstructive pulmonary disease.

Individual preference is of particular importance when it comes to deciding between radiotherapy and surgery, for example, and the risk of incontinence following surgery for some patients might be more acceptable than the risk of bowel disturbance following radiotherapy.

Tumour factors include prostate specific antigen (PSA), and the stage and the grade (see last week's Update, C+D, April 18, p17). A PSA of above 20ng/ml is commonly used as a cut-off for radical treatment, as is the presence of metastatic (but not locally-advanced) disease. A tumour with a high Gleason grade (eg 4+5=9) is more likely to be associated with non-localised disease than a tumour with a lower Gleason grade. While this in itself does not mean that a patient with a Gleason grade 9 tumour should not be offered radical treatments, it does mean that if surgery is to be performed the patient should be properly counselled regarding the posibility that histology will reveal cancer cells close to the epithelium, which increases the risk of recurrence and the likely need for further treatment.

Conservative approaches

Watchful waiting

This term is applied to men who are not suitable for radical treatment because of age or the disease stage. The patient is observed until symptoms occur or until the PSA reaches a level where hormonal treatment should be considered. It is not appropriate for younger fitter men.

Active monitoring or active surveillance

Younger patients with localised or locally-advanced disease can be offered active monitoring, which means they are treated if and when they develop clinical symptoms or signs of disease progression. Locally-advanced disease is defined as prostate cancer that has extended out of the prostatic capsule and invaded surrounding structures, but with no evidence of metastasis on staging, ie clinical stage T3a to T4b.

Because more men die with prostate cancer than because of it patients often choose this option. The patient has regular PSA checks (usually every four to six months) and may require repeat biopsy at 12 to 24 months.

Radical prostatectomy

Surgery is commonly performed for localised disease, but can also be performed for locally-advanced disease. The approach can be either open retropubic, perineal, laparoscopic or robotic-assisted, depending both on the patient (suitability and preference) and the operating surgeon. The prostate, prostatic urethra and seminal vesicles are removed, with or without lymph nodes (a so-called 'lymphadenectomy'). If possible, nerve-sparing surgery is performed, which reduces the risks of post-operative erectile dysfunction. The bladder neck is joined to the urethra, an 'anastomosis'.

Complications include general risks (bleeding, infection, pain, deep vein thrombosis, pulmonary embolism) and those specific to this procedure, such as injury to surrounding structures (including the rectum), a collection of lymph (a lymphocele), erectile dysfunction, incontinence and bladder neck stenosis. Some of the advantages of newer procedures, such as robotic-assisted laparoscopic surgery, are the increased rates of potency and reduced rates of incontinence[1]. The patient stay after a robotic procedure is usually one to two

C+D's archive of Update, MUR tips and Practical Approach articles at
www.chemistanddruggist.co.uk/education

days, whereas it is seven to 10 days after an open procedure. However, the results for each operation depend not only on each institution but also on each individual surgeon.

After surgery, the PSA should fall to less than 0.1ng/ml or less than 0.01ng/ml if a super-sensitive assay system is used. Disease progression is defined as a PSA of greater than 0.2ng/ml and this occurs in about 30 per cent of patients by 10 years[2]. The risks of disease progression are increased by a high Gleason grade, a high pre-operative PSA, the presence of positive lymph nodes after resection and the presence of a positive margin on the resected specimen. Management then includes observation, salvage radiotherapy or hormone therapy.

Radical radiotherapy

External beam radiotherapy is used to treat the prostate (with or without the lymph nodes) and is given on a daily basis for six weeks with a total dose of 72Gy or more. It is commonly offered as a radical treatment to patients with localised or locally-advanced disease, frequently in combination with hormone therapy in the latter group. Relative contraindications include severe lower urinary tract symptoms and inflammatory bowel disease, as these can be made much worse by radiotherapy.

Side effects include moderate lower urinary tract symptoms, haematuria, gastrointestinal symptoms (diarrhoea, abdominal pain and bleeding) and impotence. Newer techniques of radiotherapy (conformal radiotherapy and image-guided 'tomotherapy') have helped to reduce the side effects.

PSA is used for follow-up, and disease progression is defined as three consecutive PSA rises at least four months apart for two years. The absolute values are not specific, compared to post-prostatectomy values, because the prostate remains in-situ, but the 'nadir' PSA represents the lowest post-treatment value for each patient. The risk of disease progression is increased by a high pre-treatment PSA, a high Gleason grade, a high clinical stage and a high number of involved biopsies (tumour percentage). Management of patients who have a PSA rise is commonly by hormone therapy.

Drug treatment

Prostate epithelial cells require androgens for their growth. These androgens come primarily from the testes (Leydig cells), under the control of the pituitary gland. A further 5 per cent of the androgens are synthesised by the adrenal cortex, again under the control of the pituitary gland. Circulating testosterone is then converted to dihydrotestosterone and binds to the androgen receptor, which subsequently controls cell growth. The concept of hormone therapy in prostate cancer management was first recognised in 1941 by Huggins and Hodges[2]. Today, androgen deprivation is most commonly achieved by medical treatments, rather than surgical castration (orchidectomy).

Drug treatment is most commonly used for patients in whom surgery or radiotherapy is not indicated, ie in patients who have metastatic disease, or in patients who have disease progression during active monitoring and who are unfit for surgery or radiotherapy. However, it can also be used in combination with radiotherapy, as mentioned previously. Although treatment is initiated in hospital by a urologist or oncologist, follow-up is most often the responsibility of the GP. This is done by six-monthly PSA checks. A small proportion of patients will have disease progression without a PSA rise, and these patients will present with worsening symptoms.

LHRH (luteinising hormone-releasing hormone) agonists (gonadorelin analogues) are the most commonly used 'medical castration' agents. Examples are goserelin and leuprorelin, administered by subcutaneous or intramuscular injection. LHRH usually stimulates the action of the anterior pituitary gland but, if given in excess, can be used to suppress this action. However, LHRH agonists cause an initial surge in LH release before its depression, and the resulting increase in testosterone may progress the cancer. This 'tumour flare' occurs in around 20 per cent of patients and can include symptoms of spinal cord compression, which is a medical emergency. To prevent this, patients are usually given anti-androgens (ie androgen receptor antagonists) for one week before and one to two weeks after the first injection of LHRH agonists.

Side effects of LHRH agonists include lack of energy, hot flushes and sweats, weight gain, gynaecomastia, anaemia, a reduction in libido and erectile dysfunction. If LHRH agonists are given long-term, the patient is at risk of osteoporosis so should have a bone density scan and possibly receive bisphosphonates.

Anti-androgens (androgen receptor antagonists) include bicalutamide, flutamide, and cyproterone acetate, administered as tablets. They are used as described above and in combination with LHRH agonists to achieve so-called complete androgen blockade (CAB). CAB is used to treat patients in whom there has been a PSA rise from the nadir while on LHRH agonists; around a quarter will show a favourable response.

Cyproterone acetate also has some action against LH and, because of its progestational activity, a low dose is used for the treatment of hot flushes caused by LHRH agonists. Side effects include gynaecomastia, liver dysfunction, and gastrointestinal symptoms.

There is no evidence that CAB as defined currently improves survival. Paradoxically, if a patient's disease progressed while on CAB, around a quarter show a reduction in PSA on removal of the anti-androgen. The exact mechanism for this is unknown. Patients who progress while on CAB and then progress after removal of the anti-androgen can be given oestrogens such as diethylstilboestrol or corticosteroids. Clearly, these patients are at high risk of thrombo-embolic events and aspirin is usually also given.

Other treatments

There are several other treatment options, including brachytherapy, a form of local radiation therapy within the prostate with radioactive seed implantation. This is well accepted.

Other new treatments include high-intensity focused ultrasound (HIFU) and cryotherapy. Although there is not yet good follow-up data, they might have a place in salvage therapy for patients who have progressed following a different treatment.

Chemotherapy has a role in patients with androgen-independent metastatic disease, both for palliation and cancer control. Commonly used agents include docetaxel and mitoxantrone.

ProtecT

At present, we do not know the best treatment to offer each patient with localised prostate cancer. To address this, a national, multi-centre randomised controlled trial was started in 2001, called the ProtecT (Prostate testing for cancer and Treatment) Study. In this study, men are invited between the ages of 50 and 69 years from GP surgeries in Sheffield, Bristol, Newcastle, Edinburgh, Cardiff, Birmingham, Leicester, Cambridge and Leeds. The study is investigating general health, quality of life, prostate cancer development, treatment outcome, length of life, and cost implications.

With the results expected from 2011 onwards, we should then be able to advise patients with localised prostate cancer regarding treatment options: either surgery (radical prostatectomy), radiotherapy (radical conformal) or active monitoring (monitoring with regular check-ups).

Naomi Sharma is a urology academic registrar, Addenbrooke's Hospital, Cambridge.

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See page 20 for details.

NEXT WEEK: When would you recommend orlistat for someone trying to lose weight? Next week's Update looks at the place of the recent POM to P switch in obesity management.

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For Practical Approach references see

Treatments for prostate cancer – recording your CPD

Reflect

What are the complications of radical prostatectomy? Which patients can be treated with radiotherapy? How do gonadorelin analogues work? What is brachytherapy?

Plan

This article describes treatments for prostate cancer including prostatectomy, radiotherapy and drug treatment. It also discusses watchful waiting and active monitoring, and the factors considered when deciding which treatment is most suitable.

Act

For more details about surgery for prostate cancer read the information on the Prostate Cancer Charity website **http://tinyurl.com/6bvwr4** and for more about how radiotherapy is used to treat prostate cancer, see the Cancerbackup website **http://tinyurl.com/dbr3u6,** which also includes information on brachytherapy.

Revise the drug therapies used in prostate cancer from the BNF and the Prostate Cancer Charity website **http://tinyurl.com/cxtgxy** which looks at the pros and cons of hormone treatment and side effects. How could you use this material when counselling patients?

More information about cryotherapy and high-intensity focused ultrasound can be found on the Cancerbackup website **http://tinyurl.com/db62ga.**

Evaluate

Many treatments for prostate cancer have side effects such as incontinence and erectile dysfunction. Revise your knowledge of these; the Prostate Cancer Charity has information at http://tinyurl.com/cc4tyx and http://tinyurl.com/csblqo.

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Practical Approach

Once-daily dose timing

"The GPs I give prescribing advice to were very impressed with the presentation you made about dose timing of cardiovascular drugs with a once-daily dose," says David Spencer, pharmacist at the Update Pharmacy to his pre-registration pharmacist trainee, Joanna Savage (see C+D, February 14, 2009, p22).

"They found it very valuable," David continues. "In fact, they've asked me if you can talk to them about other once-daily medicines. Do you know about any others?"

Joanna replies: "Yes, in the project I did during my six months at the hospital I covered anti-gastric secretion drugs, antidepressants, thyroxine, hypoglycaemics, asthma medication and NSAIDs."

"The next prescribing meeting has a very crowded agenda," says David, "so could you just cover the first two this time and we'll leave the others for a later date? But they still want it backed up with evidence, as last time."

"Sure, I can do that," replies Joanna.

Question

What were the main points of Joanna's presentation in relation to anti-gastric secretion drugs and antidepressants?

Answer

Anti-gastric secretion drugs

- **PPIs:** Optimal dosing time depends partly on the symptoms being treated. With pantoprazole, morning dosing is significantly superior to evening with regard to 24-hour intragastric pH and should be recommended for the treatment of acid-related diseases.[1] Morning dosing of omeprazole is preferable for patients with reflux induced by physical activity, and evening for patients with nocturnal reflux.[2] Lansoprazole is usually given in the morning, but patients with mainly nocturnal symptoms may be best treated by evening dosing.[3] Evening dosing of rabeprazole normalises more effectively total oesophageal exposure and provides significantly better control of nocturnal gastro-oesophageal reflux disease than morning dosing.[4] A possible reason for the better efficacy of evening dosing of PPIs generally is the higher calorie intake at dinner compared with breakfast, and the theory that the more potent the stimulus the more proton pumps that will be exposed for consecutive inhibition by the PPI.
- **Histamine-2 receptor antagonists:** Early evening dosing (6pm) of ranitidine and famotidine provides better control of nocturnal acidity and more satisfactory control of 24-hour acidity than bedtime dosing (11pm).[5-7] A possible explanation for improved efficacy is that high plasma concentrations of oral H_2RAs are present when stimuli to acid secretion are high after dinner.
- **Antidepressants:** Dosing time has no influence on the efficacies of citalopram, sertraline and venlafaxine. Fluoxetine is recommended in the morning, although a trial has shown no difference in efficacy and toleration regardless of dosing time.[8]

Fluvoxamine and fluvoxamine maleate are better tolerated with bedtime dosing. Mirtazapine, being a potent blocker of histamine receptors, tends to have a sedative effect, favouring bedtime administration. Paroxetine is usually administered in the morning, which can reduce the ADR of insomnia, while bedtime dosing is preferable if patients feel drowsy after morning dosing.

References at www.chemistanddruggist.co.uk/practicalapproach

This article can help with the following CPD competencies: G1, G1c, G1e, G1s, G2h, G6p, G8g, C4b.

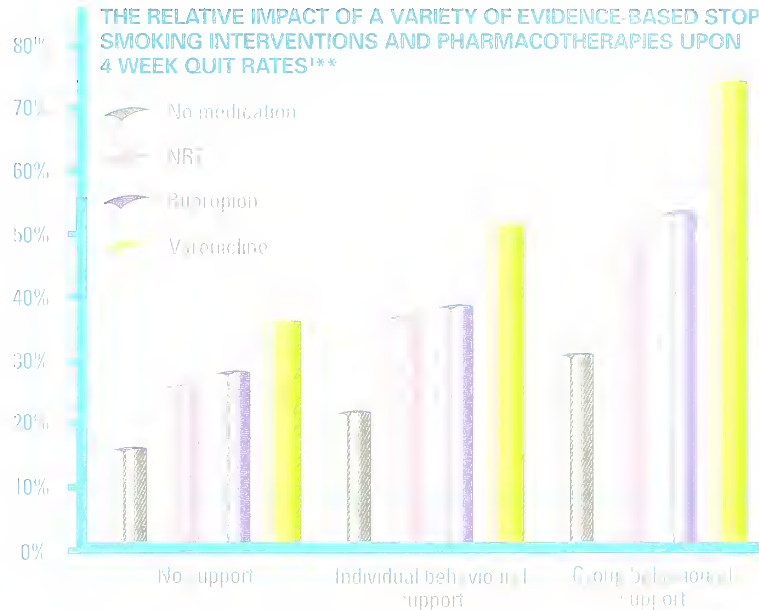
See http://tinyurl.com/68ox7b

NEW

NHS Stop Smoking Services:

SERVICE AND MONITORING GUIDANCE 2009/10[1*]

- To optimise success all recommended treatments will need to be offered as a first line intervention[1]
- When options are offered to smokers they should be offered with supporting information on the relative chances of success[1]
- These data have been prepared by the authors of this guidance from the Cochrane Reviews by performing indirect comparisons between treatments across different settings. The 4 week quit rates have not been measured directly but have been extrapolated from longer term quit rates[1]



Adapted from the Cochrane Database of Systematic Reviews.

*This is a selection [illegible] from the NHS Stop Smoking Services: [illegible] Monitoring Guidance 2009/10. [illegible] publications

**Adapted from table [illegible] from the NHS Stop Smoking Services: Service and Monitoring Guidance 2009/10

CHAMPIX – An evidence-based choice in smoking cessation[1-5]

CHAMPIX Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION – UK (See Champix Summary of Product Characteristics for full Prescribing Information). Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation** White, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 1.0" on the other side. **Indications** Champix is indicated for smoking cessation in adults. **Dosage** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8-End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment [illegible] tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency.** *Mild to moderate renal impairment:* No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events:* Dosing may be reduced to 1 mg once daily. *Severe renal impairment:* 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease:* Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions** *Effect of smoking cessation:* Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Depression, suicidal ideation and behaviour and suicide attempts have been reported in patients attempting to quit smoking with Champix in the post-marketing experience. Not all patients had stopped smoking at the time of onset of symptoms and not all patients had known pre-existing psychiatric illness. Champix should be discontinued immediately if agitation, depressed mood or changes in behaviour that are of concern for the doctor, the patient, family, or caregivers are observed or if the patient develops suicidal ideation or suicidal behaviour. Depressed mood, rarely including suicidal ideation and suicide attempt, may be a symptom of nicotine withdrawal. In addition, smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). The safety and efficacy of Champix in patients with serious psychiatric illness has not been established. There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients; therefore dose tapering may be considered. **Pregnancy and lactation** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product affects their ability to perform these activities. **Side-Effects** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side effects were increased appetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, [illegible] dry mouth and fatigue. See SmPC for other less commonly reported side effects. **Overdose** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category** POM. **Basic NHS cost** Pack of 25 [illegible] mg tablets Card [illegible] 003) £27.30, Pack of 28 1 mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/[illegible]) £54.60, Pack of 56 1 mg tablets HDPE Bottle (EU/1/06/360/002) £54.60, Pack of [illegible] 1 mg tablets Card (EU/1/06/360/[illegible]) £54.60. Not all pack sizes may be marketed [illegible] marketed at launch.

Marketing Authorisation Holder Pfizer Limited, Sandwich, Kent CT13 9NJ, United Kingdom. **Further information on request** Pfizer Limited, [illegible] Oaks, Dorking Road, Tadworth, Surrey, KT20 7NS. [illegible]

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For further information, please contact Pfizer Medical Information on 01304 616161 or email medinfo.uk@pfizer.com

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CHAMPIX
varenicline tartrate

Pfizer Date of preparation April 2009 CHA752

Tackling constipation

This condition is misunderstood and neglected and with 1 per cent of the population having a chronic problem, Gavin Atkin examines treatment options

Two events have drawn attention to constipation lately – or at least they should have if the condition received the attention it deserves.

The first was a BMJ review of the condition; the second was fresh evidence supporting a minimally invasive surgical treatment. The BMJ review reveals little that would surprise pharmacists, but the new evidence on the technique of sacral nerve stimulation is exciting, as it reveals that a minimally invasive technique already in use in managing incontinence can also produce significant improvements in chronic constipation.

So this is a good time to find out more about current thinking on managing constipation. Consultant physician and director of the Durham Constipation Clinic Dr Yan Yiannakou has a lot to say on the subject.

Constipation, he argues, is misunderstood and neglected: it has no patient group and the OTC medicines used in its treatment haven't had the support that pharmaceutical companies and physicians have lent other drug groups.

The most important issue in constipation to understand, he argues, is that constipation has severe effects on quality of life for a significant minority. "People think it's just a nuisance but there is a group, 1 per cent of the population, whose symptoms start at a young age, usually as children or young adults. Some 95 per cent are women, and they normally present at some time between childhood and 40 years.

"They have functional constipation – the word 'functional' here means it is not caused by lack of fibre, constipating drugs, neurological disorders, by lack of exercise or not drinking water, or by the fact that they're elderly and don't do or eat much.

"This is a serious condition. We have shown that quality of life is worse in patients coming to clinic with constipation than in patients coming to clinic with colitis: they get a lot of pain that can be daily or constant, and they get severe bloating, lethargy and tiredness, and headaches," he says.

"These people have usually had constipation for years. They have often stuffed themselves with fibre and fluid and run round the block with no benefit, and they've heard the usual advice a thousand times. A lot feel guilty because of the suggestion that their problem is their fault – but they don't respond to fibre-based laxatives or eating more fibre. The fibre just ferments, producing gas and adding to the bloating.

"We now have strong evidence of physiological abnormality in these individuals at various levels, including biochemical imbalances in the gut wall, problems in the nervous control of the bowel and abnormalities in the pain pathways. What they need is for someone to say 'you've tried fibre, exercise and all of that – what you need now is a laxative that isn't fibre-based'."

> THE WESTERN PEDESTAL TOILET IS A DISASTER. WE REALLY SHOULD GO BACK TO HAVING HOLES IN THE GROUND

Dr Yiannakou is also concerned that laxatives have a bad name they don't deserve. "Several things came together in the 1950s and 60s to suggest that laxatives caused problems in the gut and contributed to cancer. All of these bits of research later proved to be wrong – but because they all came together and seemed to support each other they were given a lot of credit.

"The message that laxatives should be avoided still appeared in the BNF until just a few years ago, even though it was based on very poor evidence. Until that change it gave certain indications only, for example where a patient with angina found that straining was causing angina symptoms."

Although that warning has been removed, those attitudes still remain, says Dr Yiannakou. "I still get asked to ring pharmacists worried about doling out stimulant laxatives to patients time after time," he says.

Another puzzle Dr Yiannakou is keen to explain is why laxative effects commonly wear off over time. "The effects of a laxative depend partly on the bacterial colonisation of the bowel, and this changes over the space of a couple of years. This means the effects of a laxative will probably change, but it isn't a sign that the condition's getting worse. You just have to accept that the laxative's effect is changing and it's time to switch to a different product."

Given that there are two populations who present with constipation – one with more easily managed constipation and one with a chronic type of condition that undermines quality of life, how should customers complaining of constipation be managed?

"Anyone with new onset constipation for more than a couple of weeks needs to have their bowel investigated," says Dr Yiannakou. "Constipation can be a sign of bowel cancer, and even young people should see their doctor.

"They can also have lifestyle advice, including diet, exercise, drinking water and their toileting position," he says. In case that last point comes as a surprise, Dr Yiannakou is emphatic on toileting position. "It has to be said that the Western pedestal toilet is a disaster. We really should go back to having holes in the ground, but an alternative is to get the patient to get their feet raised up on a stool when they're on the toilet.

"The other group of patients, the longstanding constipation sufferers who find that their current laxative treatment is becoming less effective, should be offered a different form of non-fibre based laxative."

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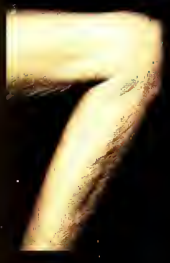

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Prescribing Information, United Kingdom. Please read the Summary of Product Characteristics before prescribing. Presentation: ***BuTrans*** 5 µg/h, 10 µg/h, 20 µg/h. Transdermal beige patches containing buprenorphine. **Indications:** Treatment of non-malignant pain of moderate intensity when an opioid is necessary for obtaining adequate analgesia. ***BuTrans*** is not suitable for the treatment of acute pain. **Dosage and administration:** ***BuTrans*** should be administered every 7 days. *Elderly and adults over 18 years only:* Use the 5 µg/h patch for at least the first 3 days of treatment, before increasing the dose if necessary. Do not use more than two patches at a time. **Contra-indications:** Known buprenorphine or excipient hypersensitivity, opioid dependent patients, narcotic withdrawal treatment, respiratory depression, use of MAO inhibitors within the past 2 weeks, myasthenia gravis, delirium tremens, pregnancy and lactation. **Precautions and warnings:** Convulsive disorders, head injury, shock, reduced consciousness of uncertain origin, intracranial lesions or increased intracranial pressure, severe hepatic impairment, history of drug abuse. Not recommended immediately postoperatively or for situations characterised by a narrow therapeutic index or for rapidly varying analgesic requirements. May affect ability to drive or use machinery. **Interactions:** Monoamine oxidase inhibitors (MAOIs), CNS depressants (e.g. benzodiazepines, opioid derivatives, antidepressants, sedatives, alcohol, anxiolytics, neuroleptics, clonidine). CYP 3A4 inhibitors and inducers, products reducing hepatic blood flow (e.g. halothane). **Side-effects:** Common: anorexia, confusion, depression, insomnia, nervousness, headache, dizziness, somnolence, paraesthesia, vasodilation, dyspnoea, constipation, dry mouth, nausea, vomiting, abdominal pain, diarrhoea, dyspepsia, sweating, tiredness, pain, peripheral oedema, application site reaction, chest pain, pruritus, erythema, rash, exanthema, asthenia. Potentially serious side-effects also include: allergic reactions, psychotic disorder, hallucinations, nightmares, drug dependence, mood swings, dysarthria, migraine, syncope, visual disturbance, angina pectoris, palpitations, tachycardia, hypotension, hypertension, aggravated asthma, respiratory failure, diverticulitis, dysphagia, ileus, biliary colic, myalgia, depersonalisation, memory impairment, respiratory depression, urinary retention, decreased libido, pyrexia, rigors, alanine aminotransferase increased, drug withdrawal syndrome, abnormal coordination, circulatory collapse, wheezing. Please consult the SPC for details of other side-effects. **Legal category:** CD (Sch3) POM. **Package quantities and price:** 5 µg/h transdermal patch: 2 individually sealed patches, £8.80. 10 µg/h transdermal patch: 4 individually sealed patches, £32.02. 20 µg/h transdermal patch: 4 individually sealed patches, £58.31. **Marketing Authorisation numbers:** PL 16950/136-138. **Marketing Authorisation holder:** Napp Pharmaceuticals Limited, Cambridge Science Park, Milton Road, Cambridge CB4 0GW, UK. Tel: 01223 424444. Member of the Napp Pharmaceutical Group. Further information is available from Napp Pharmaceuticals Limited. **Date of preparation:** Feb 2009. ® ***BuTrans*** and the NAPP device are Registered Trade Marks.

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Date of preparation: March 2009

UK/BU-09031

Can you see another solution to the problem? Email C+D at

Ethical dilemma

A request to stop supplying narcotics

This series aims to help you make the right decisions when confronted by an ethical dilemma. Every month we present a scenario likely to arise in a community pharmacy and ask a member of the Pharmacy Law and Ethics Association (PLEA) to comment on the legal and ethical implications of the actions open to you. Readers are invited to have their say at **ethics@cmpmedica.com**

This unfortunate case perplexed the pharmacist immensely. There were so many issues to consider in deciding how to help the couple without incriminating anyone on the healthcare team.

The concerns were:

respect for the wife's autonomy in terms of her right to decide what or what not to take

her right to privacy, in balance with

her best interests.

Deliberating on such issues is not easy. It may be tempting to turn away from the whole scenario with a flat refusal to listen, but the pharmacist has been drawn in without much of a choice.

Firstly, the pharmacist needs to know the facts. Is there an erratic dispensing history or a reason for a behavioural fluctuation, eg is there an underlying disease state? A mental illness? An unanticipated side effect of the medication?

The best source of facts is the patient. She has every right to be asked and to be informed about the investigation if, in the pharmacist's judgement, there is reason for concern. It must not be a witch-hunt. It must not be the husband's desperate plea for help that drives the ethical decision-making.

If the husband's concerns are found to be valid, the pharmacist has a number of options. With the patient's informed consent, doctors may be contacted, a holistic review of her medications conducted, and local service providers possibly contacted for support.

On the other hand, if the patient refuses to co-operate and further narcotics may be harmful, then it is up to the pharmacist to decide whether or not to supply. Surely "to do no harm" is a priority? In which case, before the pharmacist refuses supply point blank, it would be wise to explain the situation to the prescriber, as there may be a reason justifying the prescription. Privacy is not compromised when healthcare providers consult each other in the context of patient care.

The pharmacist has an obligation to do his or her utmost to provide a service dedicated to the patient's best interests, at the same time paying due respect for her autonomy. Only after exhausting all other means, is it fair to refuse supply.

Betty Chaar, BPharm, MHLaw, PhD, ethicist and lecturer in pharmacy practice, University of Sydney, Australia.

Where does the law stand?

This pharmacist is caught between competing legal and ethical duties.

On the one hand, paragraph 5 of the NHS Terms of Service requires a pharmacist to provide the drugs ordered "with reasonable promptness"; and the Code of Ethics says: "Patients are entitled to expect the dispensing service provided to be... reasonably prompt."

On the other hand, an oversupply of medication is unlikely to be in the patient's best interests. For that reason, the Terms of Service allow a pharmacist to refuse to supply in certain circumstances, for example where "providing the drugs... would be contrary to the pharmacist's clinical judgement" or, with repeat prescriptions, where the pharmacist is not satisfied that the patient is taking the drug appropriately.

In addition, the NHS Act 2006 requires pharmacists, as NHS "employees", to protect the efficiency of the service. PCTs have taken action against pharmacists where they believe the oversupply of medication has jeopardised that efficiency (because it wastes NHS money).

The pharmacist must discuss the allegations with the patient and satisfy themself that they are true (and not the husband's misunderstanding or fabrication). The pharmacist may also wish to discuss the allegations with the GP but, given their sensitivity, should consider obtaining the patient's explicit consent beforehand.

If the pharmacist is satisfied that an oversupply is taking place, they can and should consider ending the supply. Whatever they do, they need to keep detailed notes in case they have to justify their actions later to the Royal Pharmaceutical Society or the PCT.

Noel Wardle, a solicitor at Charles Russell LLP, specialising in pharmacy law.

This article can help in the following CPD competencies: **G1h, G1m, G3a, G4a, G5c, G5d, G7b. See http://tinyurl.com/68ox7b**

PLEA

PLEA is an association of pharmacists interested in law and ethics, and lawyers or ethicists specialising in pharmacy, with the aim of promoting understanding of the ethical basis for professional judgement
www.wingfieldworks.co.uk/plea/index.html

Next month's Ethical dilemma: possible conflicts

LETHAL OBSESSION

Weight loss is a vital part of cardiovascular risk management and weight loss with Xenical can have a significant impact upon key risk factors.[1-5] When you help change their weight, you help change their future.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Roche Products Limited. Please contact Roche Drug Safety Centre on: 01707 367554

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References: 1. Hollander PA et al. Diabetes Care 1998; 21: 1288-1294. **2.** Hanefeld M and Sachse G. Diabetes Obes Metab 2002; 4: 415-423. **3.** Sharma AM and Golay A. J Hypertens 2002; 20: 1873-1878. **4.** Broom I et al. Br J Cardiol 2002; 9: 465-468. **5.** Torgerson JS et al. Diabetes Care 2004; 27: 155-161.

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J9792055T August 2008.

With criminals using everything from guns to acid in assaults on pharmacists and their staff, **Chris Chapman** asks if the profession needs greater protection

WHO'S LOOKING OUT FOR YOU?

Jignesh Patel, who was held up at gunpoint, says there must be a national policy to protect pharmacists against crime

Bicycles, cosmetics stands, knives, crowbars, guns, syringes and acid sprays. These are just a few of the items that have been used in assaults on pharmacies in the past year. With both the government and the Independent Pharmacy Federation saying that crime rates will soar during the recession, are pharmacists getting the support they need?

It's a question on the mind of Mukesh Waghela. Last month, as Mr Waghela closed his pharmacy in Stratford, London, two men sprayed acid into his eyes (C+D, April 18, p5). Mr Waghela was shutting up shop after dark and had planned to make some home deliveries. Now he wonders if pharmacists can continue to provide extra health services such as late-night opening and medicines delivery, if security isn't bolstered as well.

He says: "You shouldn't have to fear for your safety while you're providing a service. You shouldn't have to have eyes in the back of your head when you're trying to do your normal work."

It's not an isolated concern. According to the C+D and PDA Union Salary Survey, one in three employee pharmacists have been affected by crime in the past year. And Mr Waghela's point is echoed by other crime victims. Jignesh Patel, whose pharmacy in Plaistow, London, was held up at gunpoint on New Year's Eve says the risks are "getting higher and higher".

He adds: "Pharmacists doing these services are more and more vulnerable. We want to do services, we want to deliver to people's homes, but if we're going to be attacked on the way it makes it unsafe and people aren't going to take on the services."

If the NHS wants pharmacy to perform the advanced healthcare role set out in last year's white paper, it makes sense that the government helps protect those providing the services. The NHS has a national strategy to combat violence to service providers, spearheaded by the NHS Security Management Service (NHS SMS).

Deputy head Susan Frith says a key element is local security management specialists, who can provide support and advice to community pharmacists including conflict resolution training.

Her comments are supported by Gareth Jones, NHS liaison manager at the NPA, who says that security is the NHS SMS's "policy and operational responsibility". Both the NPA and the RPSGB contribute to the NHS SMS strategy group. And yet while hospital pharmacists are protected under the umbrella of the NHS SMS security structure, community pharmacy is still a grey area.

"The NHS SMS doesn't deal directly with the private premises of contractors," says Ms Frith. However, she adds that the organisation does "take into account the security concerns of the wider health community working outside the NHS security structure".

The RPSGB also believes that it has no responsibility in the area, saying that it "does not offer any advice or training on security".

But pharmacists should not just sit back and rely on the representatives to take care of them, say some in the sector. John Murphy, chairman of the PDA, believes contractors should do more to protect their own employees.

He says: "We tried to highlight that this was an increased problem in pharmacy, that our members were being physically or verbally abused or attacked by customers.

"We want employers to have no-tolerance policies in their pharmacies... employers have got that power but I've not seen notices up in pharmacies."

However, Jignesh Patel points out that although contractors have some responsibility, they are unable to provide training on the same scale as a national programme. Contractors, particularly independents, just aren't able to pack the same punch fighting crime as the national bodies.

He says: "I think it should be a national policy. Although it is the contractor's responsibility in terms of health and safety, there's time, funding, training... lots of issues involved."

Mr Patel adds: "At the moment, everything comes out of our bottom-line profits."

Those profits can't sustain heavy investment in the fight against crime. Services have to bow to the laws of economics. If contractors have to spend more on protecting staff before they can provide them – new services won't be adopted. The problem will only be resolved if all groups work together, Mr Patel concludes.

"We need to look at various organisations pulling together. PCTs support GPs quite a bit, and we need to make sure we're supported as well."

Unity, though, is the ingredient that's lacking in the sector's response to crime. Trying to get to the bottom of who is responsible for pharmacy security feels like a boardroom interrogation on The Apprentice. Everybody says that the problem lies with someone else.

However, one thing is clear. If pharmacy doesn't want to miss out on the potential rewards from providing new NHS services, it needs to band together fast and look after its own.

You've probably not heard of NCAS but the NHS body is likely to become a lot more familiar to pharmacists. Charged by the government with ensuring doctors and dentists practice to acceptable standards, the organisation is now responsible for addressing poor pharmacy performance. NCAS associate director **William Rial** tells you what you need to know

YOUR GUIDE TO...

What is it?

The National Clinical Assessment Service (NCAS) is an NHS body which was formed in 2001 to improve the handling of concerns about doctors' performance. In 2004, its remit was extended to include dentists, and from April 1, 2009, the service will also apply to pharmacists.

What does it do?

NCAS aims to help restore practitioners to an acceptable standard and level of practice. It is an advisory body with no statutory powers and is independent of employers and regulators. For the duration of NCAS's involvement, responsibility and ownership of the case remain with the referring body.

Who is it for?

Referrals to NCAS usually come from employers or contracting bodies although practitioners may self-refer. NCAS expects a referral on behalf of an employer or contracting body to be made by someone of seniority, such as a director of pharmacy, pharmacy superintendent or director of HR. NCAS adopts the same step-wise approach to each case it receives.

Why is it being introduced?

The broader clinical role expected of pharmacists will inevitably place their skills and services under renewed scrutiny. There will be instances where the performance of an individual practitioner gives cause for concern, and while such concerns may not warrant the immediate attention of the profession's regulator they will require further exploration. In these circumstances, individuals and organisations may struggle to progress matters constructively. Where efforts are made to address concerns locally, the process can sometimes reach an impasse – the absence of a consistent nationwide approach to addressing performance concerns locally can contribute to difficulties in resolving issues.

Who will this affect?

The NCAS Pharmacy Service will be fully integrated with the other NCAS services and will be capable of covering its entire geographical remit from its inception. NCAS services are free, at the point of use, to NHS employers and contractors. NCAS can also offer its services on a fee-paying basis to healthcare organisations that are completely independent of the National Health Services.

How will it work?

NCAS receives over 700 referrals per year; most of which result in further telephone advice or support through NCAS staff meeting the organisation and practitioner to resolve the concerns. Where necessary, this support is amplified with specialist assessment of the practitioner's performance in the workplace. NCAS adopts a formative approach and will identify areas of satisfactory practice as well as areas that require improvement. Following assessment, help is given with implementing recommendations – with the aim of restoring and assuring safe practice wherever possible.

What does it mean?

The introduction of the NCAS Pharmacy Service will, for the first time, provide pharmacists and those who manage them with access to a single expert body that is capable of advising them on the process and management of performance concerns. NCAS has more than 30 advisers. They are each hugely experienced in managing performance concerns and come from diverse backgrounds in the health services. Collectively, they have a formidable body of knowledge and expertise which pharmacy will be able to draw upon.

How is first contact made?

Initial contact with NCAS is made by telephone and callers will need to provide certain information to a member of the advice team including name,

position in the organisation and the nature of the concern being referred. At this stage, the caller would also be expected to provide details of the practitioner about whom the concern is raised, asked to provide contact details and offer a suitable time for an NCAS adviser to call back.

An appropriately qualified and experienced NCAS adviser will then contact the referrer to discuss the concerns in more depth and provide advice on how they might be addressed both in terms of process and outcome.

All advice provided by NCAS is confirmed in writing within a short period of time.

When will this start?

NCAS will extend its service to include pharmacists from April 1, 2009. Following extensive engagement with key pharmacy organisations and other stakeholders, it is developing tools and processes to ensure that the service it offers to pharmacists is of the high standard both NCAS and pharmacy will demand.

How will this benefit my business and patients?

This will provide pharmacists and the profession with an opportunity to utilise the expertise of NCAS to ensure that, where appropriate, concerns can be addressed locally in an effective and consistent manner. This will further support pharmacists in continuing to provide trusted, high quality health services to the public.

William Rial is associate director (pharmacy) at NCAS.

Further information may be found at:

www.ncas.npsa.nhs.uk

YOUR GUIDE TO... PNAs

Solicitors **David Reissner** and **Noel Wardle** from Charles Russell LLP explain what pharmaceutical needs assessments are and why they matter to you

What is it?

A pharmaceutical needs assessment will replace part of the pharmacy control of entry regime.

Currently PCTs have to consider whether it is necessary or desirable to grant an application for a new pharmacy in order to secure, in the neighbourhood, the adequate provision of pharmaceutical services.

In the future, each PCT will be required to produce a pharmaceutical needs assessment (PNA). A PCT that receives an application to open a new pharmacy in its area will have to consider whether it is satisfied that either it is necessary to grant an application to secure the needs identified in the PNA, or whether granting the application would secure improvements, or better access to pharmaceutical services having regard to the PNA.

What is it for?

The government wants PCTs to carry out a more rigorous assessment of pharmaceutical needs in their areas. New PNAs are intended to give PCTs more control in deciding what pharmaceutical needs exist in their areas and in determining applications for new pharmacies in accordance with those identified needs. By identifying needs, PNAs will also encourage applications for areas which the PCT has identified as being under-resourced.

Who will this affect?

The new control of entry regime based on PNAs will affect all pharmacy owners and prospective owners in England because whether an application for a new pharmacy is granted or not will probably depend on what the PNA says.

What does it all mean?

Opening a new pharmacy is likely to become more dependent on a PCT identifying a need and putting it into its PNA than on an applicant gathering evidence of necessity or desirability to support an application. It may lead to a reduction in new pharmacy applications being granted in some areas because certain PCTs have a history of reluctance to grant applications. However, applications for preferred sites (such as new polyclinics) may be more likely to succeed if they have the PCT's support.

Producing and keeping up-to-date PNAs will be a huge administrative burden for PCTs. The changes may lead to inconsistencies across the country as some PNAs are likely to be more thorough than others.

> IF YOU ARE LOOKING TO OPEN A NEW PHARMACY IN THE NEAR FUTURE, YOU SHOULD CONSIDER PUTTING THE APPLICATION IN BEFORE THE RULES CHANGE

When will this come into effect?

There is no fixed timetable as yet. PCTs have to produce PNAs before any changes in the regime can be implemented. Guidance has been issued by the government on the contents of PNAs, but template PNAs are still awaited. It will then take PCTs several months to produce thorough PNAs.

What can I do about it?

If you are a pharmacy owner, you should respond to any contact from the PCT regarding the production of its PNA so that you can have input into its contents. You should also make sure that you get hold of a copy of the PNA as soon as it is published.

If you are looking to open a new pharmacy in the near future, you should consider putting the application in before the rules change; once the PNA has been produced, it may be more difficult for an application to be granted if a need is not highlighted by the PNA.

Why is it being introduced?

The government commissioned a review of the control of entry system in 2007. A white paper was published on April 3, 2008, suggesting that PCTs should carry out a more rigorous assessment of local needs to allow applications to open a new pharmacy to be objectively tested. PNAs are supposed to be the "rigorous assessment".

How will it benefit my business or my patients?

The intention is that, by carrying out an assessment of pharmaceutical needs for each area, patients' pharmaceutical needs will be more adequately met.

What are the pitfalls?

If the PCT considers that there is an inadequacy in the provision of pharmaceutical services in an area in which you own a pharmacy, an application to open a new pharmacy is likely to be granted. There does not appear to be any mechanism for challenging the contents of the PNA other than through the courts.

Who are the biggest winners/losers?

The biggest winners will be those who read the PNA as soon as it comes out, see that the PCT has identified (rightly or wrongly) an inadequacy in the provision of pharmaceutical services and put in an application for a new pharmacy. The losers will be those who believe there is a need for a pharmacy in a neighbourhood but who cannot persuade the PCT to include it in its PNA, or those who own a pharmacy in an area where the PCT has highlighted a need in its PNA.

What is the timetable for this?

The Health Bill is due to reach its report stage in Parliament on April 28, 2009, but there is, as yet, no timeline for the implementation of the changes

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Dismissal law

Gareth Edwards gets you up to speed on this month's dismissal law changes

From this month, employers who fail to follow a new code of practice when dealing with discipline and grievances will be liable to pay more compensation. To avoid findings of unfair dismissal and increased awards for damages, employers must make sure that they have got to grips with the changes.

Among other things, the 2008 Employment Act has removed the statutory dismissal and grievance procedures. Employers will now be encouraged to comply with the revamped ACAS (Advisory, Conciliation and Arbitration Service) Code of Practice on Disciplinary and Grievance Procedures, which tribunals look at when hearing cases.

The code sets out key principles, but is not a substitute for the employer having their own disciplinary and grievance procedures. When issuing terms and conditions to an employee, an employer is required to specify the disciplinary and grievance procedures that apply, or to inform employees where the documents can be located. Failure to do so can lead to compensation being paid to an employee.

The code provides guidance on what is expected from an employer, and employees, when a disciplinary issue or grievance arises. It stresses the need for fairness and transparency and the use of rules and procedures.

Indeed, employment tribunals will note what is 'fair and reasonable' when deciding cases, and will consider whether the employer has followed the principles set out in the code.

It will not apply to dismissals on the basis of redundancy or the non-renewal of fixed-term contracts on their expiry.

There is no prescriptive definition of a disciplinary situation, but the code anticipates dealing with issues relating to poor performance and misconduct. However, it makes the point that some employers may have separate policies to deal with conduct, such as poor performance and harassment issues.

The code sets out key principles which need to be applied fairly by an employer and the requirements for a fair process:

- Employers are responsible for carrying out any investigations necessary to establish the facts of the case.
- Employers should inform employees of the cause of the problem and provide them with an opportunity to put their case in response before any decisions are reached.
- The code repeats details of an employee's statutory right to be accompanied at any formal disciplinary meeting.
- Following the meeting, employers must decide whether any disciplinary action is justified and inform the employee in writing of the decision.
- Employers should allow employees to appeal against any formal decision and notify the employees in writing of the outcome of an appeal hearing.

In terms of a grievance, the code simply states that grievances are concerns, problems or complaints that employees raise with their employers. The code provides only general guidance on what an employer is required to do when dealing with a grievance.

- If it is not possible for the employee to resolve the grievance informally, employees should raise the matter formally, in writing, and without unreasonable delay with a manager who is not the subject of the grievance.
- On receipt of a grievance, the employer should arrange a formal meeting without unreasonable delay. The employee should explain their grievance and be given the opportunity to say how they think it should be resolved.
- Where an employee's grievance relates to a complaint about a duty owed by the employer, then the employee has the right to be accompanied by a work colleague or a trade union representative.
- Following the meeting, the employer needs to decide whether any further investigation is required and what action it needs to take.
- Where an employee is unhappy with the outcome, they should be allowed to appeal and set out the grounds for their appeal without delay in writing.

But from this month, an employee will be able to bring a claim in the tribunal without having first raised a grievance with the employer.

As for ACAS, it will be under a new duty to continue conciliation throughout the proceedings until the case is heard.

Gareth Edwards is a partner in the employment team at Veale Wasbrough Lawyers

For more information, visit: **www.acas.org.uk/index.aspx?articleid=1364.**

Your questions answered

Why are we having more changes in this area?

Since October 2004, employers have had to grapple with statutory dispute resolution procedures which imposed minimum standards on employers when dealing with disciplinary and grievance issues. The procedures were introduced to encourage employers to resolve disputes in the workplace but failed to achieve this aim.

The government commissioned an independent review of the procedures, which found that although the statutory procedures encouraged early resolution of disputes in some cases, they created a high administrative burden with unintended negative consequences.

What are the penalties for not following the new rules?

From this month, a tribunal will be able to find that a dismissal is unfair on procedural grounds alone and reduce or eliminate the employee's compensatory award to reflect the likelihood that a dismissal would have gone ahead where a fair procedure had been followed.

A failure by employers to follow the new code of practice does not mean that tribunal proceedings will immediately follow.

However, where tribunal proceedings are issued, an employer's failure to observe the requirements of the code may result in an employment tribunal increasing the compensation payment to an employee by up to 25 per cent. Similarly, where an employee unreasonably fails to comply with the code the amount of compensation awarded may be reduced by up to 25 per cent.

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Royal Pharmaceutical Society of Great Britain **RPSGB/NPA** NPA National Pharmacy Association

Royal Pharmaceutical Society of Great Britain (RPSGB) and the National Pharmacy Association (NPA).

Call for expressions of interest for the development of training materials for the simulated patient project.

This project aims at improving the quality of advice given by community pharmacists and their staff when supplying OTC medicines and in particular 'P' medicines. The provider will be asked to develop the materials for the simulated patient visits.

The provider will have sound experience of developing training materials and will seek to achieve broad consensus by collaborating with a virtual reference group. The training provider will need to have a strong knowledge of pharmacy and a good understanding of good practice standards in the field.

The training materials are expected to be completed by end of Mid-July 2009.

Those wishing to submit an expression of interest in tendering for the contract are asked to do this via email to kim.menzies@rpsgb.org by noon on Friday **1st May 2009**. Interested parties will then be sent a short pre-qualification questionnaire for completion before the tender is issued on Tuesday the **12th of May 2009**.

For further information about the service and the procurement process, interested parties should contact Kim Menzies, Procurement Manager by email only
kim.menzies@rpsgb.org

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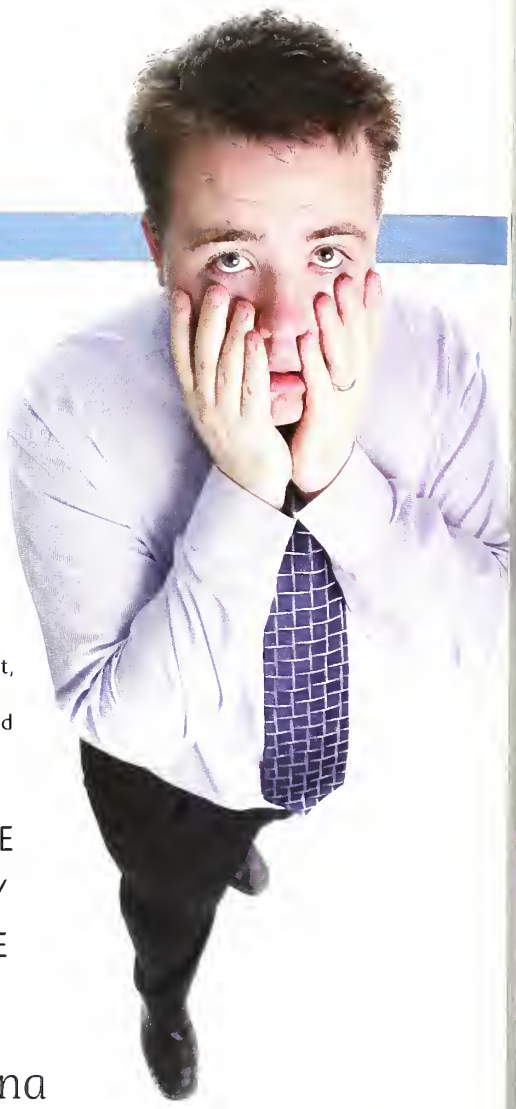
Postscript...

Mike Hewitson's diary of a new pharmacy owner



Right place ... wrong time!

I'm going to let you in on a little secret, as long as you promise not to tell my wife....

It all started a couple of weeks back: I booked myself on to the local PCT's minor ailments scheme training evening, but chose to go to a session on the other side of Dorset because my local session clashed with our wedding anniversary.

On the day of the course we had been particularly busy and I wasn't sure I could be bothered to drive for an hour and sit through the training. It was made all the worse by the fact that both my wife and daughter were having a well-earned rest, of which I was extremely jealous.

But I reminded myself that 'The Man' was soon going to be checking my CPD record and that this was going to be good for the business, and so begrudgingly I set off. After an hour of driving, I spent what seemed like an age in the seemingly impenetrable Wimborne one-way system trying to find the venue – and made it by the skin of my teeth, with two minutes to spare.

"Is this minor ailments?" I asked of a man clutching a BNF, feeling pretty confident that I had managed to locate the correct venue.

"No, this is anticoagulation."

Then came the real sledgehammer: "Minor ailments was yesterday!"

As I had already had a mouthful of the buffet, I felt morally obliged to stay. Maybe I had read my diary incorrectly, or maybe CPPE has started a guerrilla CPD campaign... either way I still haven't had the courage to tell my wife!

> I SPENT WHAT SEEMED LIKE AN AGE IN THE SEEMINGLY IMPENETRABLE WIMBORNE ONE-WAY SYSTEM

RAIDERS OF THE LOST ARCHIVES

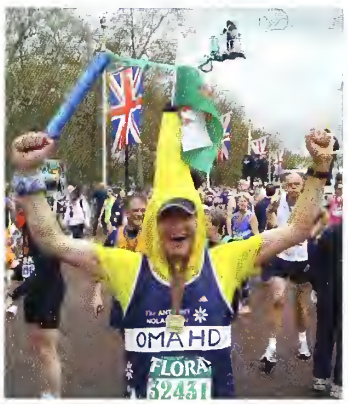
C+D 1859-2009 Celebrating 150 years in pharmacy

PostScript has a confession to make. It has no idea what half the adverts in the trade pages of December 1859's C+D are actually trying to sell.

Some of the items are self-evident (if a little bizarre), such as vanilla-flavoured tobacco, cod-liver oil cakes and chemicals designed to "recover old harsh cider". The problem comes with the quack pages.

Can anyone imagine when you would use "Dr Steers' opodeldoc"? What do you think "James's pills for the complexion might contain? And why would anybody want to use "turkey sponge, eau de cologne and leeches" at the same time?

Email your answers to **postscript@cmpmedica.com**. The best guess or guesses, as judged by PostScript, will receive a C+D goody bag.



Top banana

What do you call a Welshman dressed as a banana? If you spot one in this Sunday's London Marathon, it's likely to be Asda superintendent John Evans.

John (pictured completing last year's race in his trademark costume) is running on behalf of three-year-old leukaemia sufferer Seth Mills, who is currently recovering from a stem cell transplant. John hopes to raise £2,000 for the Anthony Nolan Trust, to help children like Seth and their families.

John completed last year's race in a very impressive three hours 51 minutes, but of this year's hopes he cautions: "I am a lot older this year..."

You can sponsor John at www.justgiving.com/runninglondonforseth
Did you run the London Marathon this year?
Email postscript@cmpmedica.com

More research from the UBO*

*That's the University of the Bleeding Obvious. PostScript is aware that we've probably gone about this before but, honestly, we would like to know who dreams up some of the research that clogs up our inbox on a daily basis.

If osteoporosis suffers don't take their biphosphonate treatment they suffer more fractures and money is wasted. You don't say. Children with low self-control are more likely to become overweight in later life. Really?

And another of our recent favourites: patients prescribed hypnotics are more likely to be involved in road traffic accidents. Well, yes, that's why the packets advise patients not to drive while taking them.

In addition, in a no-way-comprehensive-or-scientific perusal of the cancer risk emails that also flood in, PostScript has concluded that it is safe to eat only raw broccoli and tomatoes. The possible effects of nutrient deficiencies from such a restricted diet are another matter altogether.

Springboard

Springboard Pre-registration Training Programme

The **Medway School of Pharmacy**, in partnership with **C+D**, is launching **Springboard**, an exciting new pre-registration training programme. **Springboard** will cover all aspects of the community pharmacy experience and assist the trainee in making a smooth transition from student to professional.

The programme will consist of eight in-house study days covering:

- Responding to symptoms
- Law and Ethics
- Controlled Drug regulations
- Medicines use reviews
- Drug Tariff
- Pharmaceutical calculations
- Dressings and wound management
- Monitored dose units
- Smoking cessation
- Drug misuse
- Management
- Communication skills
- First aid
- The NHS and how it works
- Influencing your PCT
- Auditing your services
- Clinical cases using the BNF
- Practice exam questions

The programme will enable the student to meet the appropriate competences in the RPSGB pre-registration student handbook, and offer support to pre-reg tutors. There will also be a tutor training day. Students will have access to a member of staff at the university and the university's facilities.

This programme is unique in that students will have the opportunity to be accredited to provide medicines use reviews. Additionally students will be able to accumulate credits by completing distance learning courses included in the programme that can be put towards a postgraduate qualification.

All eight student study days and the tutor day will be held at Medway School of Pharmacy in Kent. The cost of the full course is £1,500 +VAT per student.

For more information on the **Springboard** course, complete the slip below and return to:
Pauline Sanderson, C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

☐ **YES**, please send me more information on the **Springboard** pre-registration training programme

Name

Address

Postcode

Email

C+D
in association with

Medway School of Pharmacy

University of Kent

The University of Greenwich

Levonelle One Step is launching its first ever TV campaign in April, raising awareness of emergency contraception and its availability at pharmacies among an even greater number of women. **Stock up to meet demand.**

Levonelle® One Step™ 1500 microgram tablet
Prescribing Information (Refer to the Summary of Product Characteristics (SmPC) before prescribing) **Presentation:** One tablet containing 1500µg levonorgestrel. **Uses:** Emergency contraception within 72 hours of unprotected intercourse or failure of contraception. Not recommended for young women under 16 without medical supervision. **Dosage and administration:** One tablet taken as soon as possible, preferably within 12 hours, and no later than 72 hours after unprotected intercourse. Vomiting, or other causes of malabsorption (such as Crohn's), might impair the efficacy of Levonelle One Step. If vomiting occurs within 3 hours of taking the tablet, another tablet should be taken immediately. Use at any time in the menstrual cycle unless period is overdue. After use, advise using barrier methods until next period. Regular hormonal contraception can be continued. **Contraindications:** Hypersensitivity to any of the ingredients of the preparation. **Warnings and precautions:** Levonelle One Step is suitable only as an emergency measure. Advise women presenting for repeat courses to consider long-term methods of contraception. Levonelle One Step does not prevent a pregnancy in every instance. If timing of intercourse is uncertain or occurred more than 72 hours earlier, conception may have already occurred. Following treatment, if the next menstrual period is abnormal or more than five days late, women should be referred to a doctor so that pregnancy may be excluded. If pregnancy occurs, evaluate for ectopic pregnancy. Ectopic pregnancy risk is low. Ectopic pregnancy may continue despite uterine bleeding. Explain importance of follow-up appointment and possible alteration to timing of next period (few days earlier or later). Exclude pregnancy in users of regular hormonal contraception if no bleeding occurs in the next pill-free period. Not recommended for women with severe hepatic dysfunction. Emergency contraception does not protect against sexually transmitted infections. Repeat administration within a menstrual cycle is not advisable due to possible disturbances of the cycle. Efficacy might be impaired in women with malabsorption syndromes or by interaction with concurrent drugs including barbiturates (e.g. primidone), phenytoin, carbamazepine, herbal medicines containing Hypericum perforatum (St John's wort), rifampicin, ritonavir, rifabutin, griseofulvin. Medicines containing levonorgestrel may increase the risk of ciclosporin toxicity. Women with malabsorption syndromes o on interacting medicines should be referred to a doctor Levonelle One Step contains 142.5mg lactose. Take this into account for women with galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption Epidemiological studies indicate no adverse effects of progestogens on the foetus but there is no data available for doses greater than 1.5 mg levonorgestrel. Animal studies showed virilisation of female foetuses at high doses Levonorgestrel is secreted into breast milk. Advise breast feeding women to take the tablet immediately after a breast feed. **Side-effects:** Nausea, low abdominal pain, fatigue, headache, dizziness, breast tenderness, vomiting and diarrhoea. Bleeding patterns may be temporarily disturbed. **Trade price:** £13.83 per tablet **Legal classification:** P **PL Number:** PL 05276/0020 **PL Holder**: Medimpex UK Limited, 127 Shirland Road, London, W9 2EP **Distributor:** Schering Health Care Limited, The Brow, Burgess Hill, West Sussex, RH15 9NE. Levonelle One Step is a registered trademark of Bayer Schering Pharma AG (formerly Schering AG). Date of revision: March 2009

Bayer HealthCare
Bayer Schering Pharma

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Bayer Schering Pharma; Tel: 01635 563500, Fax: 01635 563703, E-mail: phdsguk@bayer.co.uk

9LVN16 Date of preparation: April 2009